Hampton Village Pediatrics

Patient Name: _____ **Date of Birth:** _____ **Male:( ) Female:( ) Preferred Language:** _____

Home Address: _____ **City :**_____ **Zip:** _____ **Race:** _____

Sibling Names and Ages (ex: Jack, 9): _____

Pharmacy Name and Cross Street: _____

PARENT/GUARDIAN INFORMATION

Primary Family Email: _____

Parent Name: _____ **Date of Birth :** _____

Home Address: ***(if different from child):*** _____

Mobile Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Employer:

Parent Name: _____ **Date of Birth:** _____

Home Address: ***(if different from child):*** _____

Mobile Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Employer:

Insurance Name: _____ **Member ID:** _____ **Group #:** _____

Insurance Address: _____ **Policy Holder Name:** _____ **DOB:** _____

Alternate Contact (relative or friend):_____ **Phone:** _____

Relationship to patient: _____

Hampton Village Pediatrics

As the guardian of _____ I give Hampton Village Pediatrics, LLC permission to treat and/or immunize my child in the event that I am unable to accompany him or her to the office. I understand that in all situations the doctors prefer to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving advance consent to any medical procedure the physician deems necessary.

I hereby give my consent for Hampton Village Pediatrics to use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO)(Hampton Village Pediatrics' Notice of Privacy Practices provides a more complete description of such uses and disclosures.)I have the right to review the Notice of Privacy Practices prior to signing this consent. Hampton Village Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hampton Village Pediatrics' Privacy Officer at [16 Hampton Village Plz, Suite 220 St. Louis, Mo 63109].With this consent, Hampton Village Pediatrics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my child's clinical care, including laboratory results among others. With this consent, Hampton Village Pediatrics may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Hampton Village Pediatrics restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Hampton Village Pediatrics' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Hampton Village Pediatrics may decline to provide treatment to my child.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES. I HEREBY AUTHORIZE ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO HAMPTON VILLAGE PEDIATRICS, LLC FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES AS DESIGNATED BY MY INSURANCE COMPANY. I AM ALSO RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE. I AUTHORIZE HAMPTON VILLAGE PEDIATRICS, LLC & DR. MELISSA WHITSON TO RELEASE INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED. I HAVE ALSO RECEIVED A COPY OF MY PRIVACY NOTICE THAT DESCRIBES HOW MEDICAL INFORMATION ABOUT MY CHILD MAY BE USED AND DISCLOSED AND HOW I CAN ACCESS THIS INFORMATION.

In an effort to prevent any misunderstanding about our financial and billing policies, please take a moment to read the following information. We will gladly discuss any questions you may have about our policies. If you do not have insurance, payment is due at the time services are rendered unless alternate payment arrangements are made with our billing staff prior to your visit. To assist you, we accept cash, checks, MasterCard, Visa as forms of payment.

If you have insurance, we will file your primary and secondary insurance for you as a courtesy if you have provided us with your current and complete insurance information, and if you have authorized your insurance company to pay us directly. You must realize however, that your insurance is a contract between you and your insurance company. Payment is your responsibility. If your insurance company requires co-payments as a part of your plan, these payments are collected during our check-in process. Please keep in mind that if a service is not a covered benefit in your insurance plan, you are responsible for the payment to us.

AUTHORIZATION: I have read and agree to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claim(s) and authorize payment of benefits directly to Hampton Village Pediatrics LLC. I understand I am financially responsible to Hampton Village Pediatrics LLC for charges not covered or denied by my insurance company. I further agree to pay the cost of collection, court cost, and other reasonable fees should they be required in the event of my non-payment. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____ Relationship to Patient: _____ Today's Date: _____