PLEASE FILL OUT COMPLETELY

2018

Children's Urgent Care and Pediatric Clinic
1600 W SUNSET RD SUITE A
HENDERSON, NV 89014

Patient #1 _____ **Male / Female DOB:** _____
Ethnicity: _____ Race: _____ Language: _____
Patient #2 _____ **Male / Female DOB:** _____
Ethnicity: _____ Race: _____ Language: _____
Patient #3 _____ **Male / Female DOB:** _____
Ethnicity: _____ Race: _____ Language: _____

Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____
*** **E-MAIL ADDRESS:** _____ ***

FATHER: _____ **SSN:** _____
Date of Birth: _____ Phone: _____ Cell: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Work Phone: _____ Insurance Plan: _____
Insurance Policy #: _____ Group #: _____

MOTHER: _____ **SSN:** _____
Date of Birth: _____ Phone: _____ Cell: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Work Phone: _____ Insurance Plan: _____
Insurance Policy #: _____ Group #: _____

INSURANCE CARRIER: Father___ Mother___ Other_____

HOW DID YOU HEAR ABOUT US? GOOGLE/YELP/FACEBOOK/OTHER(PLEASE SPECIFY) _____

EMERGENCY CONTACT NAME: _____
Address_____City_____State_____
Phone_____ Relationship_____ Zip_____

NOTICE:

Please give a 24 hour notice to cancel appointments, there will be a $25.00 fee for all No-Show appointments!!

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to Children's Urgent Care and I understand that I am financially responsible for charges for medical services rendered to the above name patient regardless of insurance coverage, including amount not limited to any and all immunizations. In the event of collections proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due.

_____

Parent/ Guardian/ Foster Parent/ Guarantor of patient Date

FAMILY/CHILDREN'S URGENT CARE AND PEDIATRIC CLINIC
1600 W. SUNSET RD. SUITE A
HENDERSON NV, 89014
(702) 898-6400

I authorize the use/discloser of health information regarding my child / or myself as described below for the treatment, payment and health care operations (tpo).

Patient(s) Name: _____

_____

Patient Date of Birth: _____/_____

A.) Organization authorized to provide use or disclose the information ie: family members, physicians or others

1.) _____
2.) _____
3.) _____

B.) Organization(s) authorized to receive the information ie: School, Daycare Centers or others.

1.) _____
2.) _____
3.) _____

C.) Please specify below records authorized for release.

□ Immunization Records □ Lab Results □ X-Ray Results □ All Medical Records

D.) This authorization will expire on: _____

I understand that I may revoke this authorization (*except to the extent that action was already taken in reliance on this signed authorization*) at any time by notifying Children's Urgent Care and Pediatric Clinic in writing.

I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (*if applicable*).

I may inspect or copy any information used or disclosed under this agreement and I have the right to receive a copy of this form.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

I understand that this form does not constitute legal advice and covers only federal, not state laws.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Print Name **Relationship**

CHILDREN'S URGENT CARE & PEDIATRIC CLINIC

FINANCIAL POLICY

We are committed to providing you and your child with the best possible medical care. If you have special financial needs, we are willing to work with you if we are informed *before* your visit. The following information is provided to avoid any misunderstanding or disagreement concerning payment for the services rendered. ***We will file insurance as a COURTESY; YOU ARE ULTIMATELY RESPONSIBLE FOR ALL CHARGES.***

1) Our office accepts most insurance plans
   It is your responsibility to:
   - Bring your insurance card and ID to all visits
   - Pay your Co-pay and/ or any deductible at each visit. Payment can be made by cash or Visa, MasterCard, American Express, or Discover. **We do NOT accept checks for CO-PAYS. We do NOT bill for co pays.**
   - **Pay in full for any medical services that are not covered by your insurance policy.**
2) If you have an insurance that we are not contracted with, Payment must be made in full before being seen. You will be classified as a Self Pay patient and receive special pricing.
3) If your insurance is an HMO or POS, you may be required to have a PCP. If we are NOT your child's PCP we cannot see your child for well exams.
4) ***You are financially responsible for any amount not covered by your insurance.***
5) If you have any questions regarding your insurance, we are happy to help: However, specific coverage issues need to be directed to your insurance plan.
6) ***IF PAYMENT IS NOT MADE BY YOUR INSURANCE WITHIN 90 DAYS OF THE DATE OF SERVICE, YOU WILL BE BILLED.***
7) ***IF your insurance is requesting additional information from YOU before paying and that information is NOT received, you WILL be billed.***
8) In cases of divorce and/or separation; the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit.
9) If you fail to make payment in full for services rendered with in 60 days, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of outstanding balances. Accounts sent to collections can lead to dismissal from our practice.
10) ANY injuries that may be caused by third party liability (auto accidents, etc) are to be paid in full at the time of service. We do NOT do Medical Liens.
11) If you **NO SHOW** for a scheduled appointment, you **WILL BE CHARGED A $25.00 NO SHOW FEE.** Medicaid patients will no longer be allowed schedule appointments and must be seen on a "walk-in" basis.

*******As of January 1, 2015, ALL statements will be sent electronically. You must activate your patient portal account in order to receive your statements. *******

Patient name _____ DOB _____

_____ _____

Signature of Parent/ Guardian Date

FAMILY/CHILDREN'S URGENT CARE AND PEDIATRIC CLINIC
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Prescription Medication Consent Form

The Providers at Family/Children's Urgent Care & Pediatric clinic use an electronic medical records system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information.

To optimize the use of this electronic capability, and coordinate your care between us and your specialist, we ask that patients allow us to access their medication history through the RxHub.

Please check only one of the following:

☐ I consent to allow my provider to access all my medication history

☐ I DO NOT consent to my provider accessing any of my medication history.

Name of Patient(s): _____/_____

Signature: _____ Date: _____