www.averapedsplus.org

ACCOUNT FORM

FOR OFFICE USE ONLY
Patient # ____________________
Guarantor # _________________

Date ________________________

First Name _________________________ Middle Name _______________________ Last Name __________________________

Date of Birth_____________________ Sex M/F Race _______________ Social Security # ___________________________

Address____ City________________________ State________ Zip___________

Home Phone ( )________________Cell Phone ( )________________Primary Care Physician__________________________

Father's Name_______________________________________
SSN___________________________ DOB_______________
Address____
City_______________________ State______ Zip__________
Home Phone__________________ Cell #________________
Employer____
Occupation___________________ Race _________________
Employment status____________________________________
Address ____
Work Phone ____

Mother's Name ______________________________________
SSN___________________________DOB _________________
Address____
City________________________ State________ Zip_________
Home Phone__________________ Cell #__________________
Employer____
Occupation___________________ Race __________________
Employment status_____________________________________
Address ____
Work Phone ____

Emergency Contact **(SOMEONE THAT DOES NOT LIVE IN THE HOME)**

Name ____ Home Phone ( )__________________ Cell ____________________

Address____ City____________________State________ Zip___________

Employer ____ Work Phone ( )___________________________

Relationship to Patient ____

Primary Insurance
Insurance Co____
Policyholder's Name___________________________________
Address ____
Effective Date _______________________________________
ID # ____
Group # ____

Secondary Insurance
Insurance Co ____
Policyholder's Name ___________________________________
Address ____
Effective Date ____
ID # ____
Group # ____

Choice of Pharmacy ____
How did you hear about us? ___ Radio ___ Yellow pages ___ Newspaper ___ Web page
___Word of mouth (name _____________________________) ___ Other _______________________

Update (office use only)____

AUTHORIZATION INFORMATION

I request payment of authorized benefits be made on my behalf to the provider for any services furnished for me. I authorize my holder of medical information to release to insurance carriers any information needed to determine benefits payable for services provided. I further authorize the release of necessary information and medical records as required to assure continuity of care with other health care providers, for reimbursement or for accreditation purposes.

I am responsible to pay for all services received, regardless of my insurance coverage, I am responsible for my co-pay or 20% at time of service.

I authorize the release of medical information to the following family members (if none, write none in the first blank):

____________________ ____________________

____________________ ____________________

____________________ ____________________

Signature Date

AUTHORIZATION FOR TREATMENT

I hereby give consent to the Pediatrics Plus physicians, mid-levels and staff for medical treatment, diagnostic and/or surgical procedures.

Signature Relationship to Patient Date

ABOUT OUR NOTICE OF PRIVACY PRACTICES
at Avera Pediatrics Plus

In Compliance with the law, we are committed to protecting your personal health information.

The Attached Notice of Privacy Practices state:

- **Our obligations under law with respect to your personal health information.**
- **How we may use and disclose the health information that we keep about you.**
- **Your rights relating to your personal health information.**
- **Our rights to change our Notice of Privacy Practices.**
- **How to file a complaint if you believe your privacy rights have been violated.**
- **The conditions that apply to uses and disclosures not described in this Notice.**
- **The person to contact for further information about our privacy practices.**

We are required by law to give you a copy of this Notice and to obtain your written acknowledgement that you have received a copy of this Notice.

PATIENT ACKNOWLEDGMENT OF RECEIPT

I, ___________________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices at Pediatrics Plus.

Patient's Signature **Relationship to Patient** **Date**

Signature of Parent or Patient's Representative (If applicable) **Relationship to Patient** **Date**

DOCUMENTATION OF GOOD FAITH EFFORTS

- ❑ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient parent legal guarding declined to acknowledge the receipt of the Notice of Privacy Practices.
- ❑ The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.
- ❑ Other ____.

Witness **Date**