VILLAGE PEDIATRICS

Please check your preferred provider:

☐ **Dr. C. Ashley Wright, MD** ☐ **Alana Blakeslee, PA-C** ☐ **Kristen Charles, CPNP**

PATIENT INFORMATION

(please print clearly)

Patient Name:_____ Date of Birth: _____/_____/_____ Sex: M ☐ F ☐

First **Middle** **Last**

Primary Language Spoke: _____ Race/Ethnicity: _____

Primary Address: _____ City: _____State: ____ Zip: _____

Home Phone:_____

Mother's Name: _____ Father's Name:_____

Cell Phone:_____ Cell Phone:_____

Address: _____ Address: _____

DOB:_____ DOB:_____

Email:_____ Email:_____

Employer:_____ Employer:_____

**How did you hear about Village Pediatrics? _____

EMERGENCY CONTACT INFORMATION

(other than persons listed above)

Name: _____ Phone: (_____) _____-_____ Relationship to patient: _____

PREFERRED PHARMACY INFORMATION

(This information will be kept on file and set your child's default location for electronic prescriptions)

Pharmacy Name: _____ Address: _____ City:_____

INSURANCE INFORMATION

Insurance information is a necessary part of your child's medical record. We will do our best to direct your child's care and need for any specialist consults, lab work, and other medically necessary testing according to your managed care guidelines. However, ***it is the ultimate responsibility of the parent/policy holder to verify that all facilities and specialists that our providers refer you to are within your health plan network.***

POLICY HOLDER'S NAME: _____ SSN: _____ DOB: _____

PRIMARY INSURANCE: _____ MEMBER ID: _____ GROUP #: _____

ADDRESS (if different from above) _____

Please provide the front office with a copy of your current insurance card(s). Please update our office with any change to your insurance prior to your appointment. *** Please make our front office staff aware if your child has a secondary insurance policy ***

PRIVACY INFORMATION

Village Pediatrics personnel must have permission from the parent/ legal guardian to relay patient's medical information over the phone/email. Please list the names of who we may relay information to in the event that you are unavailable. If you do not give specific permission for us to speak to family members, we will assume that you do not want any information relayed to anyone else in your household.

HOME PHONE ☐ *MOM'S CELL PHONE* ☐ *DAD'S CELL PHONE* ☐ *OTHER:*_____

May we email regarding the patient account: *Yes* ☐ *No* ☐ ***Would you like to be added to our Patient Portal?*** *Yes* ☐ *No* ☐

By signing below, I hereby authorize Village Pediatrics to treat the above named patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in my child's care. I have read and understand the Village Pediatrics Office and Financial Policy.

Parent/Legal Guardian Printed Name: _____ Relationship to Patient: _____

Signature of Parent/Legal Guardian: _____ Date: _____/_____/_____

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VILLAGE PEDIATRICS

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

Medication Allergies:

_____

_____

Current Medications:

_____

_____

_____

Surgeries: *(list with month & year of procedure)*

_____

_____

_____

Hospitalizatons:

_____

_____

_____

Childhood Conditions *(check all that apply)*

- ☐ Allergies:_____
- ☐ ADHD
- ☐ Asthma
- ☐ ChickenPox
- ☐ Concussion age:_____
- ☐ COVID-19 date:_____
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Eczema
- ☐ Heart Murmur
- ☐ Seizures/Epilepsy

Other: _____

Social History: *(check all that apply)*

- ☐ Attends Daycare
- ☐ Exposed to second hand smoke
- ☐ Pets at home (If so, type?)

_____

Prenatal Complications:

_____

Birth History:

Birth Hospital:_____

City/State/Country:_____

Gestational age in weeks: _____

Birth Weight:_____ Birth Length: _____

- ☐ Circumcised
- ☐ Antibiotics
- ☐ Jaundice
- ☐ Breathing Problems
- ☐ Adopted

Complications not listed:

_____

_____

Family History *(check all that apply)*

	Mom	Dad	Sibling	Grandparent
Diabetes	☐	☐	☐	☐
Heart Condition	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐
Sickle Cell	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Sudden cardiac death (under age 50 years)	☐	☐	☐	☐

Child's Siblings

	Name	DOB	Brother or Sister
Sib #1:	_____	_____	_____
Sib #2:	_____	_____	_____
Sib #3:	_____	_____	_____
Sib #4:	_____	_____	_____
Sib #5:	_____	_____	_____

GENERAL OFFICE AND FINANCIAL POLICIES

At Village Pediatrics, we strive to provide exceptional care for your children from birth through age 18. In order to achieve this, we have outlined our practice policies for you. These signed policies will be kept in your child's chart. If you wish to have a copy for your records, please request one once completed.

Please review and initial that you understand the following statements:

___**Appointments**: Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

___ **Insurance**: The patient is expected to present an insurance card at *each* visit. If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is a contract between you and your insurance company. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges. Any noncovered charges are due upon receipt of a statement from our office within 30 days**. It is the parent's responsibility to contact the insurance company and confirm that the child's doctor is "In Network" with their specific insurance plan. If our doctors are "Out of Network," the parent will be responsible for any charges not covered.**

___Payments: Copayments and deductibles are due at time of service. If the financially responsible party is not the person bringing in the patient please make arrangements for payment to be given at time of service.

___ **Self-pay Accounts**: Patients with no insurance will be expected to pay at the time of service. We offer a self-pay rate for those who do not have insurance. Please see the front desk, email us or give us a call to get quotes.

___ Late Arrivals: As a courtesy, please arrive at least 10 minutes prior to your appointment. If you are 15 minutes late or more, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patient.

___ Missed Appointments/ No Call No Show: Please recognize that we reserve this time for your child. Please call and inform us once you know you will not be able to make your appointment. If you cancel with less than 2 hours notice, you will be charged a no-show fee of $30 for sick appointments/ well checks and $50 for med checks. (Three no shows will result in a review from the Primary Care Provider and may result in dismissal from our practice.)

___ Walk-In **Patients:** While scheduled appointments are preferred, the unexpected happens! If you must walk-in, know that we will do our best to fit you in but you may have a wait time.

___ Daycare/Camp/School/Sports Forms: We are happy to fill out forms that you may need for your child that require a signature. However, HIPAA laws prevent us from being able to fax them to your child's daycare, camp, or school. You may drop off, bring in or email forms. Please allow 3 business days (5-7 days during peak season May- September.)

___ **Medication Refills:** Please call the office in advance to get refills on prescriptions. Medications for ADHD or depression/anxiety may require an office visit if it has been three months since your last medication check.

___ **Referrals:** If your insurance contract requires a referral to see a specialist or for other services such as physical therapy or radiology procedures, you must receive a referral from our office prior to receiving that care. Referrals may require an office visit. Please allow 7 days for a referral to be processed. You may be financially responsible for charges incurred if you receive care from a specialist without a referral.

___ **Child Custody/Divorce Cases:** The office will bill the responsible party for the patient's date of service. It will be the responsibility of the parent or guardian that brings the child in to make arrangements for any payment due at time of service. It is the parents' obligation to work out an agreement themselves or through the court system.

___ **Respectful Behavior:** Our policy is to treat everyone who enters or calls our office with the kindness and respect we would like to receive ourselves. We understand that sometimes upsetting situations occur. However, we have a zero-tolerance policy for parents/guardians/patients who use curse words, threatening, and/or vulgar language with our staff. If this occurs, your family will be dismissed from our practice.

___**Responsible Party:** In order to be HIPAA compliant, we must have the responsible party sign this form. If the responsible party is anyone other than the Primary Insurance carrier, we must have the following:

Responsible Party's DOB: ____/____/____ Responsible Party's SS# _____

Responsible Party's Printed Name: _____

Name(s) of Patient(s) and Date of Birth(s): _____

_____

_____

_____

I have read, understand and agree to the above Village Pediatrics Financial and General Office Policy. I also understand and agree that such terms may be amended by the practice at any given time.

Signature: _____ Date: ____/____/____

Printed Name of Signer: _____

Village Pediatrics
Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as a part of my child's healthcare,Village Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnosis, treatments, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to their care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available within Village Pediatrics' HIPAA Notice of Privacy Practices which is available for review upon my request. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that Village Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Village Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Village Pediatrics change their notice, I will be notified of such.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as a part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient Name *Patient DOB*

_____ _____

Parent/Guardian Printed Name *Relationship to Patient*

_____ _____

Signature of Parent/Guardian *Date*

Village Pediatrics
5340 S Quebec St, Ste 210S
Greenwood Village, CO 80111
Ph: 303-850-7337
Fax:303-850-7362

CONSENT TO SEEK MEDICAL TREATMENT OF MINOR

In the event you are unable to bring your child in we must have this form on file for any person(s) over the age of 18 seeking medical care for your child.

I, _____, give my permission for the
(Print your name here, Parent or Guardian)

following person(s) to bring my children in for medical attention at Village Pediatrics:

_____ _____
(Print first and last name) **(Print first and last name)**

_____ _____
(Print first and last name) **(Print first and last name)**

Please allow the person(s) listed above to bring my child(ren), listed below, in to receive treatment by Village Pediatrics doctors and affiliates.

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

I may be reached at: (_____) _____-_____ with any questions or concerns.

_____ _____
Signature of Parent/Guardian Date

VILLAGE PEDIATRICS

NEWBORN VISITS

It is the responsibility of patient's parent/guardian to notify the insurance subscriber's employer and insurance company of the child's birth. It is **highly recommended** this be done within **7 days** of birth. This **MUST** be done **within 30 days** after the child's birth date.

If the newborn child has not been added to the insurance policy within the 30 days following birth, any claims within that time period will be denied by the insurance company and the patient's parent/guardian will be responsible for the total balance.

If your insurance plan is a Health Maintenance Organization (HMO), you will also be required to assign a "primary care physician" to your child.

PATIENT PRINTED NAME	PATIENT DOB
PARENT/GUARDIAN PRINTED NAME	RELATIONSHIP TO PATIENT
SIGNATURE OF PARENT/GUARDIAN	DATE