www.luvkidspediatrics.com

Patient Intake Form

Child's Name: _____ Today's Date: _____

Child's DOB: _____ Sex: _____ Address: _____

Mother's Name: _____ Occupation: _____

Mother's Email Address: _____

Genetic Parent? Y / N if no, explain: _____

Phone (Cell): _____ (Work): _____

Father's Name: _____ Occupation: _____

Father's Email Address: _____

Genetic Parent? Y / N if no, explain: _____

Phone (Cell)_____ (Work): _____

Primary Language Spoken in the home: _____

How did you hear about Luv Kids Pediatrics?

_____

Does your child have a nickname? _____

_____

EMERGENCY CONTACT INFORMATION (other than parents):

Name: _____ Relationship to Child: _____

Phone Number: _____

Name: _____ Relationship to Child: _____

Phone Number: _____

Primary Insurance: _____Member ID: _____

Subscriber on Policy: _____Subscriber DOB: _____

Policy Holder: _____

Secondary Insurance: _____ Member ID: _____

Subscriber on Policy: _____Subscriber DOB: _____

Policy Holder: _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Pharmacy Information:

What pharmacy do you routinely use so we may process prescription and prescription refills?

Name: _____ Phone Number: _____

Address: _____ City: _____ Zip Code: _____

Authorization to Treat Minor

I, _____hereby authorize the following person(s) to bring my child(ren) in for medical treatment.

I also allow them to make any medical decisions that are in the best interest of my child.

I understand that this person is required to bring a picture ID with them to the visit along with my child's insurance card(s) and any co-payment that are due at the time of visit. Without a picture ID the child will NOT be seen. Failure to present insurance card(s) and any co-payments due may result in the child not being scheduled.

I can be reached at _____ for any questions and/or concerns.

Person(s) authorized to bring the child to medical appointments:

1)Name: _____ Relationship: _____
2)Name: _____ Relationship: _____
3)Name: _____ Relationship: _____

_____ _____
Parent/Guardian (printed) **Parent/Guardian (signature)**

This authorization will remain active unless a written statement is received by the parent/guardian to revoke an authorized person.

OFFICE POLICIES & PROCEDURES

Effective January 1, 2021 the following policies have been implemented:

1. At the time of check-in at EVERY visit, you will be required to provide your insurance card and identification (DL, state ID, military ID or any legal ID). All insurances will be verified upon arrival. All deductibles, co-pays, and/or coinsurance amounts will be due at the time of service. Please verify that patient's insurance is active prior to your appointment.
2. If you are a new patient, please come to your appointment at least 15-20 minutes before the scheduled appointment time to complete the registration process.
3. Any routine call backs, prescriptions, or documents left for the physician will be completed within 48 hours.
4. At the time of service, if your account reflects and outstanding balance, you will be asked to pay the balance in FULL before you can check in.
5. If you do not have your insurance card at every office visit you will be considered as self-pay for that date of service.
6. There is a $25.00 service fee for any returned checks. In addition, ALL expenses incurred to recover outstanding balances will be payable immediately (including but not limited to collection agency fees and legal fees).
7. There will be a $20.00 no call no show fee for appointments (see appointment policy).

MEDICAL RECORDS RELEASE POLICY AND PROCEDURES

1. A medical records release must be filled out or requested by the parent or legal guardian of the patient prior to the copying of any medical records. Please request or fill out one release per patient.
2. If you are transferring to another physician you may complete a medical records request for your child's records to be forwarded to your new provider this will be charged to you at the time of service. Please allow 30 business days for this transfer to be completed.
3. All shot records will be copied one-time as a courtesy for your personal use. All additional copies will have been charged to you at the time of service. Please allow 2 business days for this process to be completed.
4. All daycare/school and sports physicals or similar forms will be provided upon your request and will be charged to you at the time you are requesting. Duplicate copies of these forms will be available within 2 business days and will be an additional charge to you at the time of service.

I have read and understand the ***OFFICE POLICIES & PROCEDURES*** and ***MEDICAL RECORDS RELEASE POLICY AND PROCEDURES.***

_____ _____
Printed Name of parent/legal representative **Date**

_____ _____
Signature of parent/legal representative **Date**