BAKER PEDIATRICS
PARTNERSHIP WITH FAMILIES

First:_____ Middle:_____ Last:_____

Date of Birth: _____ Sex: Male / Female

Nickname/Preferred Name: _____

Race: (Circle One)

American Indian/Alaska Native
Aisan
Black/African American
Native Hawaiian/Pacific Islander
White/Caucasian
Decline
Other:_____

Ethnicity(circle one)

Hispanic or Latino
Not Hispanic or Latino
Decline

Demographic Information

Street Address: _____ City: _____ State: _____

Zip: _____

Home Phone: _____

Parent/Guardian Name and Number: _____

Parent/Guardian Name and Number: _____

Please circle which phone number is primary

Email Address: _____

Preferred Pharmacy(please specify town and street):_____

Parents / Legal Guardian

*Mother / Legal Guardian: _____ Date of Birth:_____

Lives with Child: Yes / No

*Father / Legal Guardian: _____ Date of Birth: _____

Lives with Child: Yes / No

Insurance Information – A copy of your insurance card is required (front and back) *

Financially Responsible Person (please specify if address is different than above):

_____

Primary Insurance Plan: _____ Policy #: _____

Secondary Insurance Plan: _____ Policy #: _____

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Billing and Fees

All co-payments are expected at the time of service

Missed Appointment **(if not canceled 2 hours prior)**	$30.00
Missed well appointments (**not canceled 24 hours prior)**	$50.00
Return Check	$25.00
Co-payment not paid at time of service	$20.00
School/sports/daycare/camp form **(unless associated with a well visit)**	$5.00
Transfer records out	$15.00 per patient $30.00 max. Per family

Our contracts with insurance companies require that we verify if your current coverage and co-payment at each visit. **Please bring your insurance card to every appointment**.

I have read and understand the financial policy of Baker Pediatrics,LLC and I agree to be bound by its terms. I understand and agree that such terms will remain in force for the duration of my relationship with Baker Pediatrics,LLC.

Print and Sign: _____

Date _____

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Informed Consent for Telemedicine Services

- ☐ I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when they are located at a different site than I am.
- ☐ I understand that the telemedicine visit will happen through the telephone or a video call.
- ☐ I understand that the laws that protect privacy of medical information and the confidentiality of medical information including HIPPA, also apply t\o telemedicine.
- ☐ I understand that I will be responsible for any copayments and coinsurances that apply to my telemedicine visit.
- ☐ I understand that I have the right to withhold or withdraw my consent for the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- ☐ Iunderstand that by signing this form I am consenting to receive health care services via telemedicine.

Patient Name: _____

Patient DOB: _____

Parent/Guardian Signature: _____

Date: _____

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Privacy Practices

I(we) _____ authorize Baker Pediatrics,LLC to deliver medical services to my child(children)

_____

I(we) authorize the following people to bring my child in for treatment:

Name: Relationship:

_____

Name: Relationship:

_____

Name: Relationship:

_____

Acknowledgment of Privacy Practices(copy available upon request and found on the website)

I hereby acknowledge that I reviewed or received a copy of the medical previous Notice of Privacy and I may request a copy of any amended Notice of Privacy.

Signed _____ **Date** _____

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Authorization to release Healthcare information

PATIENT NAME: _____ DOB: _____

____ This is an authorization for Baker Pediatrics to **obtain** medical information from the physician/organization named below.
____ This is an authorization for Baker Pediatrics to **release** medical information to the physician/organization named below.

Reason for record release:

_____

Physician/OrganizationName _____
Address:

_____

City: _____ State: _____
ZipCode _____
Phone: _____
Fax: _____

THIS RELEASE REQUESTS ALL RECORDS IN YOUR POSSESSION, INCLUDING, BUT NOT LIMITED TO, IMMUNIZATION RECORDS AND LABORATORY TESTING RESULTS

Name: _____ Signature: _____
Relationship to Patient: _____
Phone: _____
Witness Signature: _____
Date: _____

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Financial Policies

Baker Pediatrics follows billing guidelines,set by the federal government, for the care we provide. We are bound by our agreements with insurance companies to follow these rules precisely. Each provider is trained in the rules and carefully considers billing prior to submission.

If your child is seen for a well check-up, and there is significant additional medical diagnosis; infection, asthma, developmental delay, ADHD, eczema, or sleeping problems, then we will bill for both well check-up and for the care for the additional problem. **The care is provided on the same day, but considered two different visits by the insurance companies. Due to this, you may be charged a copay or deductible on the day of the visit, even if you are ot required to pay a copay for the well check-up.**

If your child has to return to the office at a later date for an immunization, either because they are unwell at the time of their well check-up, or because you defer getting immunization on that day for another reason, they will be seen for a follow-up visit and the visit will incur a physician charge and may require a copay or deductible.

If you have any questions about your bill, we are always happy to answer them. We are dedicated to providing the best care for you and your family.

Parent/Guardian Signature Date