Lively Pediatrics

Patient's Last Name:_____ Patient's First Name: _____

Address:_____ City:_____ State:_____ Zip:_____

Sex: □MALE □FEMALE Date of Birth: _____

Ethnicity: □1-Hispanic or Latino or Spanish origin □2-Non Hispanic or Latino or Spanish origin □3-Refuse

Race: □1-American Indian/Alaska Native □2-Asian □3-Black/African American □4-White □5-Pacific Islander □6-Refuse

Preferred Language:_____ Parents Marital Status: □Married □Divorced □Separated □Single

Home Phone:_____ Cell Phone (Mom)_____ Cell Phone (Dad) _____

Email Address:_____ Pharmacy Name:_____

How did you hear about us?_____ Pharmacy City:_____

**PRIMARY CONTACT PERSON FOR FAMILY** (this primary contact will be the preferred contact person for Reminder calls)

Relationship to the patient _____

Check one: ☐Biological ☐Step ☐Adoptive ☐Foster ☐Legal Guardian ☐Other: _____

Name:_____ Home Phone:_____ Cell Phone: _____

Address:_____ Work Phone:_____ Email: _____

City:_____ State:_____ Zip:_____ Date of Birth: _____

Do you live with patient? ☐Yes ☐No Name of Employer: _____

Check preferred means of contact for messages: ☐Home ☐Cell ☐Work ☐Email

Check preferred means of contact for Appointment Reminders: ☐Home ☐Cell ☐Work ☐Email

**SECONDARY CONTACT PERSON FOR FAMILY**

Relationship to the patient _____

Check one: ☐Biological ☐Step ☐Adoptive ☐Foster ☐Legal Guardian ☐Other: _____

Name:_____ Home Phone:_____ Cell Phone: _____

Address:_____ Work Phone:_____ Email:_____

City:_____ State:_____ Zip:_____ Date of Birth: _____

Do you live with patient? ☐Yes ☐No Name of Employer: _____

WHO HAS PRIMARY PHYSICAL CUSTODY? (if applicable) _____

*(If either biological parent has NO parental rights per a SIGNED COURT ORDER, a copy of that Court Order is required to be on file.)*

EMERGENCY CONTACT PERSON (**other than either the parent(s) or contact(s) listed above**)

Name:_____ Relationship to Patient:_____ Phone:_____

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***FINANCIAL GUARANTOR:_____ Relationship to Patient: _____

Insurance Company name:_____ Primary Insured name: _____

ID # or Member #_____ Group # _____

**PERSONS AUTHORIZED TO BRING CHILD IN FOR APPOINTMENTS** - OTHER THAN PARENTS - (must be 18 years or older)

Name:_____ Relationship to Patient:_____ DOB:_____ Phone:_____

Name:_____ Relationship to Patient:_____ DOB:_____ Phone:_____

Name:_____ Relationship to Patient:_____ DOB:_____ Phone:_____

Name:_____ Relationship to Patient:_____ DOB:_____ Phone: _____

**Patient Phone Message Consent**

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES_____ NO_____ (initial)
- Leave a detailed message with individual answering the phone YES_____ NO_____ (initial)

**Sharing of Medical Information (Other than Parents/Contacts listed above)**

I give the physician and office staff permission to discuss my medical condition with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**----------Please initial the following statements----------**

**Patient Authorization for Eprescribe** YES_____ NO_____ (initial)

ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of OCP to enroll me in the ePrescribe Program.

**Patient Authorization for PHARMACY BENEFITS MANAGER** YES_____ NO_____ (initial)

I authorize the physician and/or staff to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

**Patient Authorization for ALL PATIENTS** YES_____ NO_____ (initial)

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and staff to photograph me for medically related documentation purposes.

**Authorization for *MEDICAID PATIENTS ONLY*** YES_____ NO_____ (initial)

I authorize the physician and/or staff to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicaid claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicaid payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

**Authorization for *COMMERCIAL INSURANCE PATIENTS ONLY*** YES_____ NO_____ (initial)

I authorize the physician and/or staff to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to Lively Pediatrics, PLLC the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

## Consent To Treat

YES_____ NO_____ (initial)

I authorize and consent to the routine and emergency medical treatment for my child by Lively Pediatrics, PLLC when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required, and I waive my right of prior informed consent to such treatment. This authorization is in effect until revoked in writing by me.

## Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify us of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred are the patient's responsibility.

## *SIGNATURE*

***I acknowledge that I have received a copy of the Lively Pediatrics, PLLC Notice of Privacy Practices and the After Hours Phone Call policy and agree to the terms therein. Also, the information I have provided is accurate and agree to the terms and policies described herein.***

_____ _____

Signature (Parent/Personal Representative if under age 18) Date

_____

Print Name

_____

Personal Representative's Authority (Mom, Dad, etc.)