Families First Pediatrics
Patient Agreement/ Family Addition

Name of Children	Sex	Date of Birth	Race	Preferred Language	Patient Lives With
1. ________________	M F	________	________	________	________
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					
2. ________________	M F	________	________	________	________
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					
3. ________________	M F	________	________	________	________
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					
4. ________________	M F	________	________	________	________
Ethnicity: Hispanic Latino Not Hispanic or Latino Prefers not to answer					

Father Name______________________________DOB____________ Mother Name_____________________________DOB__________

Address ____ Address ____

City ____________________________ Zip ___________________ City ______________________________ Zip __________________

Home Phone___________________ Cell ____________________ Home Phone____________________ Cell_____________________

Wk. Phone__________________ Employer ___________________ Wk. Phone___________________ Employer __________________

Emergency Contact ______________________________ Phone__________________________ Relationship to Patient ______________

How did you hear about our office? Friend/Family: ___________________ Hospital Mailer Website Other__________________

INSURANCE INFORMATION (PROOF OF INSURANCE IS REQUIRED

(If proof of insurance is not available, patient will be considered not insured until proof is shown.)

Primary Insurance: ____Policy Holder: __________________________________

Policy Holder DOB: _____________________________Policy Holder SS#: ______________________________

If you are not able to provide a copy of the insurance card, please fill out the following:

Insurance Address: ____

Insurance Phone #: _________________________________ Insurance ID#:_______________________ Group #: _________________

Secondary Insurance: ____ Policy Holder: __________________________________

Policy Holder DOB: _____________________________Policy Holder SS#: ______________________________

If you are not able to provide a copy of the insurance card, please fill out the following:

Insurance Address: ____

Insurance Phone #: _______________________________ Insurance ID#:_________________________ Group #: _________________

I allow the following people to bring my child/children in for appointments & make medical decisions in my behalf:

_______________________________ ____________________________________ _____________________________________

I allow the following people to have access to account/billing information: ____

Signature: __________________________________ **Printed Name:** ________________________________**Date:** _____________

09/18/2018

Responsible Party/Custodial Parent Information

Responsible Party Name(s): _________________________________ DOB: ________________________

Street Address: ____

City: __________________________________ State: _____________ Zip: _______________________

Home Phone: _________________ Cell Phone: __________________ Work Phone: _________________

E-mail: _____________________________________ Employer: _________________________________

Patients you are responsible for (please list all patient for which you are responsible for):

__________________________ _______________________________ __________________________

__________________________ _______________________________ __________________________

Relationship to patient/patients: *mother* *father* *step-mom* *step-dad* *other*: ___________________

Preferred Method of contact:

Person of contact regarding billing: ________________________ Ph #: ___________________________

Preferred Method of contact for appointment reminders, Please choose only one, phone, text, email:

Person of contact regarding patient appointments: ____

Cell Phone / Text: ___________________________________ E-mail: ____________________________

Please read carefully:

- Payment and/or co-pay is due at the time of service. If copay is not paid at the time of service a $10.00 fee will be assessed to your account.
- There may be a charge of up to $100.00 for any missed appointments.
- I am responsible for knowing what my insurance does and does not cover. I am responsible for any unpaid balance after 60 days, regardless of insurance status.
- If this account is assigned to an agency for collection, I/we agree to pay all attorney fees, with or without suit, court costs, a certified letter fee up to $5.00 and a collection fee of up to 40% of balance, which will be added to the outstanding balance of my account.
- A $25.00 fee will be assessed on all returned checks. You are responsible for any certified letters fees that are charged to your account.
- I authorize care and treatment by Families First Pediatrics and release of all information to insurance and third party carriers and direct them to remit payment directly to Families First Pediatrics.
- Families First Pediatrics will not disclose medical information to anyone other than legal parent/guardian unless written authorization is provided.

Responsible Party Signature____ **Date**________________________

Printed Name____ **Driver's License Number:** __________________________

Patient Financial Agreement

Families First Pediatrics

1320 W South Jordan Parkway
South Jordan, UT 84095
(801) 254-9700

4651 W 13400 S
Riverton, UT 84096
801-987-8541

As the patient's financial representative, you understand and agree to the following:

- Payment and/or copay is due at the time of service. If copay is not paid at the time of service a $10.00 fee will be assessed to the account.
- A $25.00 fee will be assessed on all returned checks.
- There may be an after-hours fee of up to $35.00 for visits after 6:00pm and on Saturdays.
- You are responsible for the account balance after 60 days regardless of insurance coverage.
- Families First Pediatrics will not be involved with separation or divorce disputes. Therefore, the parent who consents to the treatment of a minor child is responsible for payment of services rendered.
- You are responsible for knowing your insurance coverage and benefits. **It is your responsibility to make Families First Pediatrics aware of any charges not covered by your insurance, including all immunizations.** As a courtesy, Families First Pediatrics will bill your insurance and allow them 45 days to make payment. After 45 days it is your responsibility to follow up with your insurance.
- You authorize care and treatment by Families First Pediatrics and release of all information to insurance and third party carriers and direct them to remit payments directly to Families First Pediatrics.
- If your account is in good standing with no past history of collections or bankruptcy, Families First Pediatrics will extend credit on your account for a maximum of 6 months with a minimum monthly payment of $50.00 or 1/6th of the account balance, whichever is greater.
- Accounts past 90 days will be charged interest at a rate of 1.5% monthly (18% annually). A late fee of up to $20.00 per month, plus any certified letter fees, may be charged to past due accounts.
- If the account is assigned to an agency for collections, it is agreed that the financial representative will pay all attorney fees, with or without suit, court costs, a certified mail fee of up to $5.00 and a collection fee of up to 40% of the balance, which will be added to the outstanding balance of the account. The terms of this agreement also applies to any unpaid amounts owed prior to this agreement and for services that will be rendered in the future.
- Self pay patients will receive services at a discounted rate if charges are paid in full at the time of service.
- There may be a fee of up to $25.00 for complete medical records, plus any postage if mailed.
- A notice of 48 hours for canceled appointments is appreciated. A charge of up to $100.00 may be assessed to the account if there is an excessive amount of missed appointments without notification.

Signature of Financial Representative: ______________________________

Printed Name: ______________________________ Date: ______________________

Driver's License Number: ______________________ Relationship to Patient: __________________

Patient name(s): ____

Consent for the Use and Disclosure of Protected Health Information

I hereby consent to the use and disclosure of my Protected Health Information by Families First Pediatrics/ FFP Management, LLC., their staff, and their business associates in order to carryout Treatment, Payment, or Health Care Operations. I understand that Protected Health Information means my health information which is individually identifiable (e.g. name, social security number, date of birth).

I understand that uses and disclosures for Treatment, Payment, or Health Care Operations include, but are not limited to:

- Using or disclosing health information in order to make a diagnosis or provide treatment to me,
- Submit health information to the health insurance company in order to obtain payment for treatment or services rendered,
- Share health information with other health care providers that I was referred to by Families First Pediatrics for continuation of care, and
- Review my health information during quality assessment activities and training of medical personnel.

I understand that I have a right to receive a more detailed explanation of the Provider's privacy practices prior to signing this Consent. I also understand that the terms of the *HIPAA Notice of Privacy Practices* may change and that I may request a revised notice by contacting the person listed below and that a revised notice will be posted in the patient waiting area of the Provider's office.

I understand that I have the right to request that the Provider restrict how it uses and discloses my Protected Health Information in order to carry out Treatment, Payment, or Health Care Operations. I understand that the Provider is not required to agree to the restrictions, but that if the Provider agrees, the restriction is binding.

I understand that I have a right to revoke this Consent, but that I must do so in writing. I also understand that a revocation applies to the Provider's use and disclosures made after the revocation is made.

Signed: ________________________________ Date: ______________________________

Name (Print): ___________________________ Patient Name:______________________

Human Resource Department
Families First Pediatrics/FFP Management, LLC.
1320 West South Jordan Parkway
South Jordan, Utah 84095
(801)254-9700