FAMILIES FIRST COUNSELING SERVICES

FAMILIES FIRST PEDIATRICS

FAMILIES FIRST PEDIATRIC DENTISTRY AND ORTHODONTICS

18 & OLDER DEMOGRAPHIC

PATIENT INFORMATION:

NAME: First _____ **MI** ____ **Last** _____ **DOB** ____/____/_____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer: _____ **Employer Phone #:** _____ **Cell Phone #:** _____

Marital status (circle one): Married Single Divorced Separated Widowed Prefer not to answer

ETHNICITY: Hispanic Latino Not Hispanic or Latino **GENDER IDENTITY:** M F Other _____

RACE: White African American American Indian Asian Native Hawaiian Other _____

PREFERRED LANGUAGE: English Spanish Other _____

Families First Pediatrics, Counseling and Pediatric Dentistry Orthodontics are committed to using the most up-to-date and convenient communication methods for our patients. By selecting "Yes" below, you authorize the use of your mobile number to receive scheduling, billing and other information important to your health needs.

I authorize the use of my mobile number for these purposes (circle one): Yes No INITIALS _____

INSURANCE INFORMATION

PRIMARY: Name _____ **Insurance Phone #** _____

Policy Holder Name: _____ **Policy Holder DOB:** ____/____/_____

Insurance Address: _____ **City, State, Zip:** _____

Insurance ID #: _____ **Group #:** _____

SECONDARY: Name _____ **Insurance Phone #** _____

Policy Holder Name: _____ **Policy Holder DOB:** ____/____/_____

Insurance Address: _____ **City, State, Zip:** _____

Insurance ID #: _____ **Group #:** _____

How did you hear about our office? Website Friend/Family Hospital Mailer Other: _____

Do you currently have any medical or dental concerns? Yes No

Have you seen a Dentist in the last 6 months? Yes No

Would you like to be contacted about scheduling an appointment with Families First Pediatric Dentistry? Yes No

If you would like to appoint a personal representative to act on your behalf, please complete the form below. Provide the requested information about yourself (patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative. If you have any further questions regarding the Patient Representative Designation form, please email our office at billing@ffpeds.com. This form allows a designated person to access your appointments and billing information. If you would like them to have access to your complete medical records, please fill out the attached medical release form.

Patient's Signature: _____ **Date:** _____/_____/_____

Patient's Name (please print): _____ **DOB:** _____/_____/_____

PATIENT REPRESENTATIVE DESIGNATION FORM

As required by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, you have the right to designate a person to act on your behalf with respect to your protected health information (PHI).
A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient directly. Such information could include appointment changes, messages regarding care, physician responses, and/or medication requests. A Families First Pediatrics staff member may refuse to disclose information to a person identified as a patient's personal representative if that staff member believes such information should be given directly to the patient.

PLEASE NOTE: *This form does NOT grant permission to release medical records to any designated representatives or for the designated representative to authorize any release of medical records.*

PATIENT INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT PHONE: _____

PERSONAL REPRESENTATIVE #1

DESIGNEE FULL NAME: _____ DESIGNEE DATE OF BIRTH: _____

RELATION TO PATIENT/FAMILY: _____ DESIGNEE PHONE #: _____

☐ Financial Information Only

☐ Medical Information Only

☐ Both Medical and Financial Information:

☐ INCLUDE PROXY PORTAL ACCESS: Designee Email Address: _____

PERSONAL REPRESENTATIVE #2

DESIGNEE FULL NAME: _____ DESIGNEE DATE OF BIRTH: _____

RELATION TO PATIENT/FAMILY: _____ DESIGNEE PHONE #: _____

☐ Financial Information Only

☐ Medical Information Only

☐ Both Medical and Financial Information:

☐ INCLUDE PROXY PORTAL ACCESS: Designee Email Address: _____

By signing this form, I agree and understand that I may revoke or terminate this authorization at any time by submitting a written revocation to Families First Pediatrics. I understand that provisions will otherwise remain in effect for 365 days from the date of authorization and will need to provide any additional provisions of personal representation beyond expiration of this authorization.

Patient's Signature: _____ Date: _____/_____/_____

Patient's Name (please print): _____ DOB: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____

Release of Medical Information Consent

Immunizations records may also be accessed through our Patient portal at no cost. Fill out this form in its ENTIRETY; if any section is incomplete, this from will not be processed.

Patient Name: **DOB**: **Address:** **Phone #**:

1._____

2._____

3._____

4._____

Release by (PLEASE CIRCLE ONE): Mail Email Fax Pickup

Information to be released:
____Immunizations
____Clinic/Office Notes (includes well and sick visits)
____Radiology Reports
____Labs
____Full Medical Records (all the above, this will take up to 30 days to receive)
____Mental Health Records **(PSYCHOTHERPAY NOTES WILL ONLY BE RELEASED WITH A SUBPOENA)**
____Other_____

_____ **Release to**: Families First Pediatrics
1320 W South Jordan Pkwy
South Jordan, UT 84095
P: (801) 254-9700 F: (801) 254-9755

_____ **Release from**: Families First Pediatrics
1320 W South Jordan Pkwy
South Jordan, UT 84095
P: (801) 254-9700 F: (801) 254-9755

_____ **Release to:** _____
Address:_____
City, State, Zip:_____
Fax:_____ Attn: _____
Email:_____
Phone:_____

_____ **Release from:** _____
Address:_____
City, State, Zip:_____
Fax:_____ Attn: _____
Email:_____
Phone:_____

Terms of Authorization:
_____ Initial here for one time disclosure. Otherwise this authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here: _____ (if you are going on your mission list 18 months or 2 years, depending on length)
_____ Initial here for personal use or indicate the purpose of the disclosure of your records here: _____ (i.e. Auto Claims, School, Legal, Switching Offices, etc.)

- I understand that the Families First Pediatrics, Families First Counseling and Families First Pediatric Dentistry and Orthodontics will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization
- I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply): □ Mental and behavioral health □ Substance Use Disorder □ Genetic Testing
- I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Medical Records, 1320 W South Jordan Pkwy, South Jordan, UT 84095. Records may be released before you revoke your authorization and subject to re-disclosure by the recipient and may no longer be protected under federal privacy law
- I understand that I may be charged for this information, and I agree to be financially responsible for the charge
- I understand that HIPPA laws prohibit disclosure of other facility records including: hospital records, other clinic records, and medical records sent to us by other physicians on our behalf

Patient's Signature: _____ **Date:** _____/_____/_____
Patient's Name (please print): _____ **DOB:** _____/_____/_____

PATIENT FINANCIAL AGREEMENT

As the patient, **you are responsible for knowing your insurance coverage and benefits**, and you agree to the following:

General Terms and Conditions:

- You authorize care and treatment by our office and release of all information to insurance and third-party carriers and direct them to remit payments directly to our office
- As a courtesy our office will bill your insurance company, however, if payment is not received within 60 days it is your responsibility to contact your insurance or remit payment in full
- **It is your responsibility to know what charges are not covered by your insurance and inform our staff before going back for your appointment**

Financial Implications:

- Payment and/or copay is due at the time of serviced. If the 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 If your account is in good standing with no history of collections or bankruptcy, our office will extend credit on your behalf for a maximum of six 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 an interest rate of 1.5% monthly (18% annually), plus any certified letter fees 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 letter fee of up to $5.00 and a collection fee of up to 40% of the balance
- Uninsured patients will receive a time-of-service discount 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 cancelled appointments is appreciated
- A charge of up to $100.00 may be assessed to the account if there is an excessive number of missed appointments without notification
- For Families First Counseling a **48-HOUR** notice is required for cancellation of any appointments Tuesday through Saturday. For Monday appointments notice of cancellation is required the prior Thursday by 5 pm. **If we don't receive proper notice, you will be charged $120.00 late cancellation fee.** Sessions typically run 50 minutes. If you are more than 20 minutes late for your appointment, your session may be rescheduled, and you will be billed for the time schedule

Patient's Signature: _____ **Date:** _____/_____/_____
Patient's Name (please print): _____ **DOB:** _____/_____/_____

FAMILIES FIRST MANAGEMENT
1320 W SOUTH JORDAN PKWY * SOUTH JORDAN * UT * 84095
PHONE: (801) 254-9700 * FAX: (801) 254-9755

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my Protected Health Information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to used and disclose my child's protected health information to conduct:

- Treatment (including direct or indirect treatment by healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (e.g., my insurance company);
- The day-to-day healthcare operations of your practice.
- I understand that I have a right to receive a more detailed explanation of the Families First Pediatrics' 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 department listed below and that a revised notice will be available in the patient waiting area of the Families First Pediatrics' office.
- I understand that I have the right to request that the Families First Pediatrics' restrict how it uses and discloses my Protected Health Information (PHI) in order to conduct treatment, payment, or health care operations. I understand that Families First Pediatrics is not required to agree to the restrictions, but that if Families First Pediatrics 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 Families First Pediatrics' use and disclosures made after the revocation is made.

Patient's Signature: _____ **Date:** _____/_____/_____
Patient's Name (please print): _____ **DOB:** _____/_____/_____