FAMILIES FIRST PEDIATRICS

FAMILIES FIRST COUNSELING SERVICES

FAMILIES FIRST PEDIATRIC DENTISTRY AND ORTHODONTICS

CHILD'S INFORMATION:

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

Home Address: _____

City: _____ State: _____ Zip: _____ Child lives with: _____

Marital status of parents (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 _____

PARENT INFORMATION

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

Home Address (if different from child's): _____

City: _____ State: _____ Zip: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

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

Home Address (if different from child's): _____

City: _____ State: _____ Zip: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Families First Pediatrics, Counseling and Pediatric Dentistry 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 the health needs of your child.

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

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ Insurance Phone # _____

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

Insurance Address: _____ City, State, Zip: _____

Insurance ID #: _____ Group #: _____

SECONDARY INSURANCE: _____ Insurance Phone # _____

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

Insurance Address: _____ City, State, Zip: _____

Insurance ID #: _____ Group #: _____

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____ **OK to discuss billing/appointments (circle one):** Yes No Initials _____

How did you hear about our office? Website Friend/Family Hospital Mailer Door Hanger Other_____

Does your child currently have any medical or dental concerns? Yes No

Has your child seen a Pediatric 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

FAMILIES FIRST MANAGEMENT
1320 W SO JORDAN PKWY * SO JORDAN * UT * 84095
P: (801) 254-9755 F: (801) 254-9755

PATIENT FINANCIAL AGREEMENT

As the patient's financial representative, **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.**
- Our office 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.

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 $1/6^{th}$ 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.
- Appointments must be cancelled 48 hours prior to the scheduled appointment time. In the event a patient arrives late and cannot be seen by their therapist for the full appointment time or does not call to cancel within the 48-hour timeframe a charge of up to $100.00 will be assessed to the account.

Patient Name (please print): _____ **DOB:** ____/____/_____

Signers Name (please print): _____ **Date:** ____/____/_____

Signature: _____ **Relationship to Patient:** _____

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HIPAA ACKNOWLEDMENT/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 Name (please print): _____ **DOB:** _____/_____/_____

Signers Name (please print): _____ **Date:** _____/_____/_____

Signature: _____ **Relationship to Patient:** _____

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