

Patient History and Information Form for 2010

Patient's Name _____ Today's Date _____ Date Birth _____ SS# _____ M ___ F ___

Home Address _____ City/State/Zip _____

Hm Phone _____ **Cell** _____ **E-Mail** _____

Name of School _____

Siblings _____ DOB _____ SS# _____

_____ DOB _____ SS# _____

_____ DOB _____ SS# _____

_____ DOB _____ SS# _____

Father's Name _____ DOB _____ Drivers Lic No# _____ State _____

Address (if different from pt) _____

Home Phone _____ **Cell** _____ **Work** _____ **SS#** _____

Father's Employer _____ Phone # _____

Mother's Name _____ DOB _____ Drivers Lic# _____ State _____

Address (if different from pt) _____

Home Phone _____ **Cell** _____ **Work** _____ **SS#** _____

Mother's Employer _____ Phone # _____

Primary Insurance Company _____ Co-Pay _____ Effect Date _____

Policy Holder _____ ID Number _____ Grp # _____

Receipt of Notice of Privacy Practices Form

I, _____ hereby acknowledge receipt of Physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

1. I give Pediatric Partners permission to leave lab/test results and appointment confirmation in formation on our home voice mail _____yes _____no

2. Pediatric Partners has my permission to disclose medical information to the following individuals:

Name: _____ **Relationship :** _____

Name: _____ **Relationship :** _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient:

Additional Fees

1% Billing Fee will be added for account balances over 60 days

Request for Medical Records – See Medical Record Release Form

Replacement of Standard IL Health Form (valid for most school and camp medical information requests) - \$10.00

Medical Release of Information Forms where the Standard IL form cannot be used \$10.00

Medical Necessity letters - \$10.00/letter. After hours visits -\$25.00 Sunday/Holiday Office Visit - \$100.00

No-Show Visit (scheduled and appt was not canceled 24 hours in advance) - \$35.00

Walk-In Fee - \$50.00

Phone Consultative Services will be billed to your insurance plan based on the duration of the call ranging from \$25.00 - \$50.00

\$25.00 Administrative Surcharge for processing your co-payment after your visit

Payment for these additional fees must accompany your request. In addition, if there is an outstanding balance on your account Pediatric Partners will ask you to submit payment in full for the outstanding balance at the time of your visit.

A Collection Charge of 35% of the amount due will be added to the account balance of your account if sent to our collection agency.

I have read the above policy regarding Additional Fees and I agree to the terms and the Pediatric Partners, S.C. Financial Policy.

Printed Name: _____ Date: _____

Signature: _____ Relationship to Patient _____

