Rocky River Pediatrics

FAMILY INFORMATION SLIP

One form may be used for the entire family provided that the responsible party is the same for each child.

Today's Date: _______________________

CHILDREN'S NAMES:

LAST	FIRST	MIDDLE INITIAL	NICKNAME	SEX	DATE OF BIRTH	SS#

PT. ADDRESS: ______________________________ **HOME PHONE #:** ______________

CELL #: ______________________________ **E-MAIL ADDRESS:** ______________

FATHER'S NAME: ______________________ **DATE OF BIRTH:** __________ **SS#:** ______________

ADDRESS IF DIFFERENT:______________________ **CITY/STATE/ZIP:** ______________

HOME PHONE #: ______________ **EMPLOYER:** ______________ **WORK #:** ______________

MOTHER'S NAME: ______________________ **DATE OF BIRTH:** __________ **SS#:** ______________

ADDRESS IF DIFFERENT:______________________ **CITY/STATE/ZIP:** ______________

HOME PHONE #: ______________ **EMPLOYER:** ______________ **WORK #:** ______________

IF DIVORCED OR SEPARATED LIST CUSTODIAL PARENT: ______________________________

LIST ANY STEP PARENTS AND RELATIONSHIP: ______________________________

NEAREST RELATIVE NOT LIVING WITH YOU, But close by: ______________________ **PHONE #:** ______________

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY? ______________________ **PHONE #:** ______________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ______________________ **PHONE #:** ______________

MEDICAL INSURANCE INFORMATION: (LIST PRIMARY FIRST)

COMPANY	ADDRESS	GROUP #	POLICY #	POLICY HOLDER'S NAME/RELATIONSHIP

IF MEDICAID, PLEASE SUBMIT CARD WITH ROCKY RIVER PEDIATRICS LISTED AS PRIMARY CARE PHYSICIAN.

As a parent, I understand I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Rocky River Pediatrics.

If I cannot come with my child, I agree to let ______________________ **and/or** ______________________
(Name & Relationship) **(Name & Relationship)**
give permission for any treatment. (examples of persons to name here may be stepparent, grandparent, sitter, etc.)

If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature, giving permission for treatment.

SIGNATURE REQUIRED ON OTHER SIDE

ROCKY RIVER PEDIATRICS

Authorizations and Notifications

TREATMENT: The undersigned hereby consents for the physicians and staff of Rocky River Pediatrics to administer treatment deemed advisable for the patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I give permission to release any medical information about my child's treatment (including copies of medical records) needed for payment of insurance claims, or for continuing care after s/he has been treated. I also give permission to use medical information about my child's treatment for quality assurance review purposes. I reserve the right to revoke this consent at any time and I understand my revocation will be effective no earlier than the date of my notice.

PAYMENT OF CO-PAYS AND CO-INSURANCE: I understand that RRP is committed to providing my child with the highest quality care possible. I also understand that RRP is committed to controlling costs. I acknowledge that I have a responsibility to assist with controlling costs by paying my co-pay at the time of each service, or paying my co-insurance amount at the time of each service. Well child checks may be rescheduled if account is overdue.

FEES FOR NON-CANCELLED VISITS: I understand that it is my responsibility to give my provider at least 24 hours notification if I cannot keep a scheduled appointment. If I do not provide adequate notification I may be charged for the missed appointment. I further understand that the missed appointment fee is my responsibility and my insurance carrier will not be billed.

NON-COVERED SERVICES: I understand that my physician may recommend that certain tests be performed to assist in his/her treatment/diagnosis of my child's medical condition. My insurance carrier may not cover the tests my physician feels are necessary for treatment/diagnosis. If my physician thinks the tests may not be covered by my insurance payor, I will receive advance notification and will be asked to sign a waiver stating that I accept responsibility for payment. I also understand that I have the option to decline having the tests performed.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to RRP and all physicians involved in my child's treatment or diagnosis at RRP by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of treatment of the below named patient. I unconditionally assign any insurance benefits to RRP and all physicians involved in my child's treatment and further authorize them to apply any surplus insurance benefits or any other payments received from any source to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patients or guarantor. I understand that I am financially responsible to RRP and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees, expenses, and/or interest associated with collection of the debt.

REFERRALS AND AUTHORIZATIONS: I realize that my physician may recommend that my child receive additional treatment from a specialist, and that my insurance carrier may require that my primary care provider complete a referral and/or authorization for such treatment. I acknowledge that it is my responsibility to make sure the specialist has received the completed referral/authorization prior to the visit, or I may be required to pay for the visit in full at the time of service.

By signing this document I acknowledge that I have read, understand, and will comply with its contents.

______________________________ ______________________________ _______________

Patient Signature (if applicable) (Date) Responsible Party Signature (Date) Initials