****** Please initial and sign the items on the back of this page. ******

All Better Pediatrics, PC
2021 Patient Information Sheet

Date: _____

☐ New Patient ☐ Established Patient Updated Referred By: _____

Children/Sibling Information

	Patient Name (Line 1)	Nickname	Gender	DOB	SSN
1.					
2.					
3.					
4.					

Billing Address
Father/Legal Guardian

Name _____
Birthdate _____
SSN _____
Address _____
_____
City _____ State _____ Zip _____
Phone _____ Cell _____
E-mail _____

Billing Address
Mother/Legal Guardian

Name _____
Birthdate _____
SSN _____
Address _____
_____
City _____ State _____ Zip _____
Phone _____ Cell _____
E-mail _____

Father's Employer _____
Occupation _____
Work Phone _____
Employer Address _____
_____
City _____ State _____ Zip _____

Mother's Employer _____
Occupation _____
Work Phone _____
Employer Address _____
_____
City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____
Phone _____ E-mail _____

Preferred Pharmacy _____ **Pharmacy Phone** _____

Primary Insurance Information

Insurance Carrier _____
Policy ID# _____
Policy Group _____
Policy Holder's Name _____
Policy Holder's Birthday _____

Secondary Insurance Information

Insurance Carrier _____
Policy ID# _____
Policy Group _____
Policy Holder's Name _____
Policy Holder's Birthday _____

**** Please initial and sign the items on the back of this page.****
(Over)

All Better Pediatrics, PC
Authorizations & Acknowledgments
2021

Date:_____

Assignment of insurance benefits and acceptance of financial responsibility

Initial here:_____ I authorize Pediatric and Adolescent Medicine of East Memphis, PC, D/B/A as All Better Pediatrics, to furnish information to insurance carriers concerning my or my child's illness and treatments, including information about mental health, communicable diseases, and alcohol or substance abuse. I hereby assign to All Better Pediatrics all payments for medical services. I understand that I am responsible for any amount not covered or reimbursed by insurance. Debit and credit balances under $1.00 will be written off. A $35 fee will be assessed for returned checks. A late charge of $6 will be applied to all accounts for each 28-day period past the original statement issued by our office. Interest, at the maximum rate allowed by statute, will be applied to all accounts for each 30-day period past the original statement issued by our office. In the event of non-payment, I agree to pay reasonable attorney fees, court costs, collection agency fees, and all other expenses necessary for collection. In the event your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all cost of collection including attorney fees and court cost. You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

General consent to treatment and tests

Initial here:_____ I am voluntarily seeking medical treatment for myself or my child. I consent to examination by the physician, nurse practitioner, nurse, or other health care professionals at All Better Pediatrics. I also consent to any medical procedures, laboratory tests, or other health care services ordered by the All Better Pediatrics healthcare team.

Acknowledgment of notice of privacy practices (HIPAA)

Initial here:_____ I acknowledge that I have received a copy of All Better Pediatrics' notice of privacy practices.

Authorization to leave messages

Initial here:_____ I authorize All Better Pediatrics to leave messages regarding pending appointments, tests, treatments, bills, or other health issues.

_____Home Phone _____Mobile phone _____Work Phone

No-show policy

Initial here: _____ If I do not cancel a previously scheduled appointment at least 24 hours before the appointment time, then I will be charged a $30 "no-show" fee. I understand that my insurance provider will not pay this fee, so I will be responsible for payment.

Breastfeeding services authorization and policy

Initial here:_____I acknowledge the following about being treated at All Better Pediatrics for a breastfeeding consultation.

1. All Better Pediatrics will bill my insurance for any breastfeeding services that I (Mom) receive.
2. Depending on the nature of those services, my insurance might pay for 100 percent of the allowed amount or I might be liable for a copay and/or deductible.
3. All Better Pediatrics will bill the appropriate insurance for any breastfeeding services that are provided to my child.
4. In instances where All Better Pediatrics bills breastfeeding services for the child, any coinsurance or deductible will be due.
5. At some visits, All Better Pediatrics might bill for both the mother and the child, depending on the situation and to the person to whom services are provided.

Signature of parent/guardian/responsible party____ ____Signature of parent/guardian/responsible party

Name (print):_____ Name (print):_____