PATIENT INFORMATION

Collins Pediatrics
COLLINS CARES
Providing customized and comprehensive care for children from infancy through adolescence.

PATIENT DEMOGRAPHICS

First Name :

Last Name :

Nickname :

Date Of Birth : ____ / ____ / ____ **Gender** : ☐ Male ☐ Female

Ethnicity :
Required by Louisiana Immunization Network for Kids. ***Please check one:***

- ☐ Unknown
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to specify

Race :
Required by Louisiana Immunization Network for Kids. ***Please check one:***

- ☐ American Indian or Alaskan Native
- ☐ Asian ☐ White ☐ Other Race
- ☐ Black or African American ☐ Declined to specify
- ☐ Hawaiian Native or Other Pacific Islander

Physical Address :

Mobile Phone :
If age is 18 or older

Preferred Pharmacy :

E-Mail :
If age is 18 or older

Pharmacy Phone :

Mailing Address :
If differs from physical address

PRIMARY CONTACT

First Name :

Last Name :

Social Security Number :

Date Of Birth : ____ / ____ / ____

Relationship :

Employer :

Marital Status :

Occupation :

Primary Phone :

Is this a mobile phone? ☐ Yes ☐ No

E-Mail :

If No to above, list mobile phone :

Appointments Contact Preferences
Select all that apply.

- ☐ Text Message
- ☐ Primary Phone

Register for Patient Portal?

- ☐ Yes
- ☐ No

Physical Address Same as Patient? ☐ Yes ☐ No
If No to above, list physical address:

Mailing Address Same as Patient? ☐ Yes ☐ No
If No to above, list mailing address:

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SECONDARY CONTACT

First Name :

Last Name :

Social Security Number :

Date Of Birth : ____ / ____ / ____

Relationship : ____ **Employer** : ____

Marital Status : ____ **Occupation** : ____

Primary Phone : ____ **Is this a mobile phone?** ☐ Yes ☐ No

E-Mail : ____ ***If No to above, list mobile phone*** : ____

Appointments Contact Preferences
Select all that apply.

☐ Text Message
☐ Primary Phone

Register for Patient Portal?

☐ Yes
☐ No

Physical Address Same as Patient? ☐ Yes ☐ No
If No to above, list physical address: ____

Mailing Address Same as Patient? ☐ Yes ☐ No
If No to above, list mailing address: ____

BILLING

Responsible Party :
Please check one:

☐ Primary Contact ☐ Secondary Contact ☐ Patient ☐ Other

Do you have medical insurance? ☐ Yes ☐ No

Carrier :

Policy Holder Name :

Social Security Number :

Date Of Birth : ____ / ____ / ____ **Gender** : ☐ Male ☐ Female

Relationship : ____ **Employer ID** : ____

Employer : ____ **Group** : ____

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EMERGENCY CONTACT (NOT A PARENT)

First Name :

Last Name :

Relationship :

Primary Phone : _____ **Is this a mobile phone?** ☐ Yes ☐ No

E-Mail : _____ ***If No to above, list mobile phone*** : _____

CONSENT TO TREAT

CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, MEDICATION HISTORY, AND HEALTHCARE OPERATIONS.

By signing below, you hereby consent for Collins Pediatrics, to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment, accessing/reviewing medication history, and healthcare operations. You may refuse to sign this consent form.

Information about you is protected under the federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Please check the following if applicable:

☐ You may call my home and leave a message with someone or on an answering machine if I am not available.

☐ You may call my place of employment and leave a message on an answering machine or with someone if I am not available.

☐ You may call my cell phone and leave a message on my answering machine if I am not available.

☐ You may communicate confidential information to me, including invoices for services, to the address and/or phone numbers that have been listed in my patient information. If no, please indicate the address or phone number that we may use:

Signature: _____ **Relationship:** _____

Print name: _____ **Date:** _____

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CONSENT AGREEMENT

I request that payment of authorized commercial insurance benefits be made to Collins Pediatrics for any service furnished to me or my dependent by Collins Pediatrics' providers. I authorize Collins Pediatrics to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due to the physician. These amounts could include annual deductibles, copayments, charges denied as not covered by my commercial insurance carrier, and charges denied for services determined as not medically necessary. I further understand that if Collins Pediatrics incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying all of those fees.

Consent to treat minor (under 18) in absence of a parent
I hereby authorize Collins Pediatrics to render medical treatment to my child(ren) in my absence when he/she is brought in by any other person other than myself.

Signature: _____ **Relationship:** _____

Print name: _____ **Date:** _____

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OFFICE POLICIES

Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy ensures communication and enables us to achieve our goal.

Appointments

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we request a 24-hour notice.

Insurance Plans

- It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you verify your insurance at every visit to verify that our office has the most updated card on file.
- If the insurance card/plan you present is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- It is your responsibility to understand your plan benefits. Not all plans cover well child visits, vision/hearing screenings, lab tests or physicals. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been exceeded, you will be responsible for payment.

Financial Responsibility

- According to your insurance plan, you are responsible for all co-pays, deductibles, and coinsurances.
- Co-pays are due at the time of service.
- Self-pay patients are expected to pay for services in full at the time of visit. This includes patients with out of network insurance plans. Our office will be happy to provide the necessary documentation for you to file the claim for reimbursement with your insurance company.
- Patient balances are billed monthly. We ask that you pay your statement balance after receiving your first statement. Please contact our finance office to discuss payment options.
- We accept cash, check, and all major credit cards.
- A $30.00 fee will be charged for any checks returned for insufficient funds.
- A $25.00 fee will be charged for any declined credit cards and credit card chargebacks.

Signature: _____ **Relationship:** _____

Print name: _____ **Date:** _____

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Labs and Testing

In House Labs and Testing

- Labs and tests completed in our office could be sent outside of our office and tested by an outside lab. These labs and tests are billed by that company. Some labs and tests may be costly. If you need to know the cost before the labs or tests are done, please call your insurance company. Collins Pediatrics does not have any association or affiliation with the labs and cannot control the cost or the billing of any labs and tests.

Outside Labs and Testing

- Labs and tests performed outside of our office are billed by that company. Some labs and tests may be costly. If you need to know the cost before the labs or tests are preformed, please call your insurance company. Collins Pediatrics does not have any association or affiliation with the labs and cannot control the cost or the billing of any labs and tests.

Anytime a provider at Collins Pediatrics orders labs or testing, they believe it is essential to the patients' health or the parent/guardian has requested labs and tests.

Outside Lab Facilities

Children's Hospital • LCMC • Ochsner • LabCorp • Quest

Wellness Care

- Wellness care is an essential part of keeping your child healthy and regular check-ups are required by Collins Pediatrics.

Forms

- There is no charge for a certificate of immunization given at the time of your child's visit. There is no charge for physical or medication forms presented at the time of visit.
- There is no charge to complete any additional school, camp, sports forms, or forms. We require a 48-hour turnaround time.

Medical Records

- We provide records of your child's visits with Collins Pediatrics only. All records for outside facilities or providers should be obtained from them directly.

Prescription Refills

- For monthly medication refills, we recommend 48-hour notice, during regular business hours. Please plan accordingly.

Signature: _____ **Relationship:** _____

Print name: _____ **Date:** _____