Please print clearly so that we can process your information quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (*First, M.I., Last)*_____ Date of Birth _____

Phone Number _____ Social Security # _____ Sex _____

Address _____ City/State _____ Zip _____

Ethnicity Hispanic/Non-Hispanic Race White/Asian/African American/American Indian/Pacific Islander/Other

PARENT/GUARDIAN INFORMATION

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number _____ Social Security # _____

Address _____ City/State _____ Zip _____

Employer _____ Phone Number _____

Employer Address_____

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number _____ Social Security # _____

Address _____ City/State _____ Zip _____

Employer _____ Phone Number _____

Employer Address_____

Who is guarantor (person financially responsible)? _____

EMERGENCY CONTACT (not a parent or guardian)

Name_____ Relationship to Patient _____

Address _____ City/State _____ Zip _____

Phone Number _____

I attest that all information is true and accurate.

_____ _____

Signature of Legal Guardian Date

INSURANCE INFORMATION

Insurance Company _____ Phone Number _____

Claims Address_____

Group # _____ Subscriber ID # _____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Social Security # _____ Date of Birth _____

Subscriber's Address (if different than guarantor) _____

Subscriber's Employer _____ Phone Number _____

Employer Address_____

I hereby authorize Gold Pediatrics, P.A. to furnish information concerning my/child's medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my/child's behalf by any and all insurance companies that cover the expenses incurred as the result of any diagnostic cervices or treatment provided by Gold Pediatrics, P.A.. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked by me in writing.

Signature of Legal Guardian _____ Date _____

CONSENT TO TREATMENT OF A MINOR

I hereby give my permission for Gold Pediatrics, P.A. and its physicians, nurse practitioners, and other associates to examine and treat my child whose name is listed below:

Patient's Name _____ Date of Birth _____

In addition, in the event that I cannot be contacted or am unable to attend the appointment, I hereby give my permission to the following individuals or institutions to consent to medical treatment of the above named child:

Name of Individual _____ Phone Number _____

Name of Institution _____ Phone Number _____

Parent or Guardian Name _____ Relationship to Patient _____

Parent or Guardian Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number _____

I acknowledge that Gold Pediatrics provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Parent/Guardian Signature **Date**

Office and Financial Policy

We would like to thank you for choosing Gold Pediatrics. We are committed to providing you with the best care possible. To do so, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1. You are required to bring proper identification and a current insurance card to all appointments.
2. We require 24 hours advance notice if you are unable to keep your scheduled appointment. If you do not give notice or notify us less than 24 hours prior to your appointment then it will be listed as a no-show. After three no-shows you may be dismissed from this practice.
3. If you arrive more than 15 minutes late for your appointment it may be necessary to reschedule.
4. All appointments must be scheduled. We do not accept walk-ins. If you do walk-in without an appointment, you make be asked to schedule the appointment for a later time or may have to wait until the provider has seen her scheduled patients.

Payment

1. Payment is required in full at the time of services rendered. This includes co-payments for participating insurance companies, full payment for self-pay patients, and full payment if we do not participate in your insurance plan.
2. Gold Pediatrics accepts cash, VISA, MASTERCARD, DISCOVER, and American Express. Checks will not be accepted.

Insurance

1. It is your responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement. If you are unable to pay for the visit, you may be asked to reschedule.
2. If your plan requires, you must designate Dr. Stephanie Gold as your primary care provider prior to your scheduled appointment. If Dr. Gold is not named as your primary care physician you may be asked to reschedule your appointment or you will be financially responsible for the visit.

3. It is your responsibility to understand your benefit plan. This includes knowing what services are covered, what services are not covered, participating laboratories and radiology centers, etc. You will be responsible for payment of services rendered that are not a covered benefit.
4. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co-payments are due at the time of service.

Referrals

1. Advance notice is required for all non-emergent referrals. Please allow 5 business days to complete the referral.
2. It is your responsibility to know if a selected specialist participates in your insurance plan.

Prescription Refills

1. We require 48 hours advance notice for all prescription refills.
2. Dr. Gold is responsible for all controlled substance prescriptions written. If you have a prescription that has expired or is not going to be filled, then you must return it to Dr. Gold.
3. There is a $10 fee for providing a new prescription if a controlled substance prescription has been lost or damaged.

Medical Records

1. Gold Pediatrics will provide you with a copy of your child's medical record for a fee of $25.
2. Please allow us 5 business days to complete your request.
3. We will only provide records for visits rendered at Gold Pediatrics (including consultations from specialists received while a patient of Gold Pediatrics). If you need records from a previous physician, you must request them directly from that physician.
4. There is a fee of $15 for completion of FMLA forms and $10 for school/sports/camp physicals that are not brought in at the time of the visit.

Conduct

1. It is our responsibility as adults to serve as good role models for our children. Gold Pediatrics will not tolerate inappropriate/foul language, yelling, name-calling or temper tantrums from any adults. If you are unable to act in an appropriate manner you will be asked to leave the office immediately and may be dismissed from our practice.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name(s) _____ Date _____

Parent/Guardian Name _____

Parent/Guardian Signature _____