

SUNNY PEDIATRICS

Thank you for choosing our office, in order to provide your healthcare needs accurately and efficiently, the following information is REQUIRED. All information is confidential; a copy of your insurance card will be made and placed in your medical record. All co-payments must be given at the time of service.

PLEASE FILL OUT ALL INFORMATION

Patient Name _____ Date of Birth _____
Siblings Name and DOB _____
Address _____ Apt# _____ City _____ State _____ zip _____
Male ___ Female ___ Home Phone Number _____ Cell Phone Number _____
Pharmacy Name _____ Pharmacy Phone Number _____
Referred by _____
Fathers Name _____ Driver's License# _____
Occupation _____ SSN _____ Cell Phone _____
Mothers Name _____ Driver's License # _____
Occupation _____ SSN _____ Cell Phone _____
Marital Status Married ___ Separated ___ Divorced ___ Single ___
Email Address _____
Legal Guardian's Name (if other than parent) _____ SSN _____

Person to contact in case of emergency (other than parents):

Name _____ Relation to patient _____ Phone _____
Address _____ City _____ State _____ Zip _____

***IF THERE ARE BARRIERS TO CARE BASED ON CULTURAL, RACIAL OR MEDICAL VIEWS, PLEASE NOTIFY US.

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____ Date of Birth _____
SSN _____ Insured's Address _____ City _____ State _____ ZIP _____
Home Number _____ Cell Number _____ Insurance Co. Name _____
ID# _____ Group# _____ Employer _____
Work Phone _____ Employer Address _____
City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____ Date of Birth _____
SSN _____ Insured's Address _____ City _____ State _____ ZIP _____
Home Number _____ Cell Number _____ Insurance Co. Name _____
ID# _____ Group# _____ Employer _____
Work Phone _____ Employer Address _____
City _____ State _____ Zip _____

ASSIGNMENT OF INSURANCE BENEFITS

I, THE UNDERSIGNED HEREBY AUTHORIZE SUNNY PEDIATRICS, P.C. RELEASE ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICE RENDERED OR FOR SERVICES TO BE RENDERED, ALSO, HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

ANY FEES INCURRED BY SUNNY PEDIATRICS, P.C. FOR THE PURPOSE OF COLLECTING UNPAID BALANCES WILL BE THE RESPONSIBILITY OF THE PARENT/ GUARDIAN.

SIGNATURE _____ DATE _____

NOTE: A PHOTOCOPY OF THIS FORM SHALL BE DEEMED AS VALID AND EFFECTIVE AS THE ORIGINAL.

ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE AND DESIGNATED OF DISCLOSURE

I) ACKNOWLEDGMENT OF PRACTICE'S NOTICE OF HIPPA PRIVACY:

I HAVE RECEIVED A COPY OF THE NOTICE OF HIPPA PRIVACY FOR PHYSICIAN PRACTICE.

Name of Patient	Date of Birth
Signature of Parent/Guardian	Date

II) DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS:

- A. I AGREE THAT THE PRACTICE MAY DISCLOSE CERTAIN OF MY HEALTH INFORMATION TO A FAMILY MEMBER, CLOSE PERSONAL FRIEND OR OTHER CAREGIVER, SINCE SUCH PERSON IS INVOLVED WITH MY HEALTH CARE OR PAYMENT RELATING TO MY HEALTH CARE. IN THAT CASE, THE PHYSICIAN PRACTICE WILL DISCLOSE ONLY INFORMATION THAT IS DIRECTLY RELEVANT TO THE PERSONS INVOLVMENT WITH MY HEALTH CARE OR PAYMENT RELATING TO MY HEALTH CARE. I WISH TO BE CONTACTED IN THE FOLLOWING MANNER. (CHECK ALL THAT APPLY):

TELEPHONE, WRITTEN, FAX AND EMAIL COMMUNICATION

YOU MUST CHECK ALL APPROPRIATE ACTIONS ALLOWED

Home Telephone Number: _____ <input type="checkbox"/> OK to leave message with detailed information on above number <input type="checkbox"/> Leave message with call back numbers ONLY	Written Communications: <input type="checkbox"/> OK to mail to my home address (such as postcards or letters) <input type="checkbox"/> OK to mail my work/office address <input type="checkbox"/> OK to email me: _____
Work Telephone Number: _____ <input type="checkbox"/> OK to leave message with detailed information <input type="checkbox"/> Leave message with call back numbers only	Fax Communication: OK to fax to this number: _____

- B. I DESIGNATE THE FOLLOWING PERSONS LISTED BELOW AS PERSONS INVOLVED WITH MY HEALTH CARE OR PAYMENT RELATING TO MY HEALTH CARE FOR THE PURPOSE OF THE PRACTICE MAKING THE LIMITED DISCLOSURES DESCRIBED ABOVE. I UNDERSTAND THAT I AM NOT REQUIRED TO LIST ANYONE. I ALSO UNDERSTAND THAT I MAY CHANGE THIS LIST AT ANY TIME IN WRITING.

Print Name _____	Last Four Digits of SSN(required) _____
Print Name _____	Last Four Digits of SSN(required) _____
Print Name _____	Last Four Digits of SSN(required) _____

- C. THE FOLLOWING PERSON(S) ARE NOT AUTHORIZED TO RECEIVE MY PATIENT HEALTH INFORMATION:

Print Name _____ Print Name _____

Signature of Parent/Guardian

Date _____

SUNNY PEDIATRICS POLICY AWARENESS SHEET

Please read carefully over the following office procedures and kindly sign and date the bottom. If you would like a copy, please ask the receptionist at the time of completion.

Upon arrival of your appointment, please sign in and take a seat.

PLEASE DO NOT WAIT AT THE COUNTER, AS IT COULD VIOLATE ANOTHERS PRIVACY.

DO NOT LEAVE YOUR CO-PAY ON THE COUNTER.

We are NOT responsible for missing or lost payments if they are left unattended.

1. Insurance card must be presented at EVERY visit.
2. Appropriate co-payment MUST be given prior to the visit.
I.O.U.'S ARE GRANTED ONLY IN EMERGENCY SITUATION (this never includes well visits or follow ups)
ALL I.O.U.'S MUST BE PAID WITHIN 5 DAYS. MORE THEN 1 OPEN I.O.U. PER PATIENT IS NOT PERMITTED.
3. As a courtesy to our patients we submit all bills to Primary and Secondary insurances. Be aware that there may be deductibles/coinsurances for services that will be considered the patient or Guardian's responsibility.
4. Allow 3 business days for all referrals and prior authorizations.
NO EXCEPTIONS WILL BE MADE.
5. ALL prescriptions are sent electronically. Allow your pharmacy at least one hour prior to pick up. Always call your pharmacy first prior to pick-up to confirm the prescription is ready.
6. A routine check-up/follow up is required for any patient taking a chronic medication every three months. If you request a refill, or new medication, a visit must also be scheduled
(the only exception is Fluoride Multivitamins).
7. THERE IS NO FOOD OR BEVERAGE PERMITTED IN THE OFFICE.
8. Abnormal lab results need to be discussed face-to-face with the doctor.
This means an office visit will be scheduled and a COPAY is collected.

THE FOLLOWING IS THE RECOMMENDED WELL VISIT SCHEDULE:

NEWBORN- MONTHLY VISITS UNTIL 6 MONTHS OLD

AFTER 6 MONTHS- EVERY 3 MONTHS UNTIL 2 YEARS OLD

AFTER 2 YEAR OLD VISIT- EVERY 6 MONTHS UNTIL 3 YEARS OF AGE

AFTER THE 3 YEAR OLD VISIT, WE RECOMMEND ANNUAL WELL VISITS

SIGNATURE

PRINT NAME

DATE _____

SUNNY PEDIATRICS

New Billing Policies Effective 03/20/2013

A) A parental divorce decree does NOT apply to this practice.

A divorced parent/guardian bringing a child/ or children to this office for medical services is RESPONSIBLE for the copays and ALL balances the patient(s) may incur at the time of service.

Sunny Pediatrics will issue a RECEIPT of said payments. It is up to the paying divorced parent/guardian to get reimbursed from the guarantor of the insurance through the court system.

B) Affective April 1st 2014, a \$10.00 per month charge will be incurred for balances over 60 days.

Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____

Signed _____ Relation to Patient(s) _____

Print Name _____ Date _____