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 NOFTIFY 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 INFORMATON RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOLWEGDE THAT MY SIGNITURE ON THIS DOCUMENT AUTHORIZES MY PHSYCIAN TO SUBMITT CLAIMS FOR BENEFITS, FOR SERVICE RENDERED OR FOR SERVICES TO BE RENDERED, ALSO, HEREBY ASSIGN TO THE PHYSCIAN 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 INCURED BY SUNNY PEDIATRICS, P.C. FOR THE PURPOSE OF COLLECTING UNPAID BALANCES WILL BE THE RESPONSIBILITY OF THE PARENT/ GUARDIAN. THERE WILL BE AN 18% ANNUAL INTEREST RATE CHARGED TO ALL UNPAID BALANCES AFTER 90 DAYS.

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 PHSYCIAN 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 INFORAMTION 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 INFORMAITON THAT IS DIRECTLY RELAVENT 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 AND FAX COMMUNICATION

YOU MUST CHECK ALL APPROPRIATE ACTIONS ALLOWED

Home Telephone Number:

____

____ OK to leave message with detailed information on above number

____Leave message with call back numbers ONLY

Work Telephone Number:

____

____OK to leave message with detailed information

_____ Leave message with call back numbers only

Written Communications:

____ OK to mail to my home address (such as postcards or letters)

____ OK to mail my work/office address

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____________________

______________________________ Date______________

Signature of Parent/Guardian

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.

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____________________