KIDZ1ST INFORMATION UPDATE WORKSHEET 2017

PARENT/GUARDIAN #1

_____ _____ _____
Relation to child | Last Name | First Name

_____ _____ _____ _____
Date of Birth | Social Security Number | Preferred Language | Preferred email address

Address_____ _____ _____ _____ _____
Number & Street | Apt # | City | State | Zip Code

☐ Reminder calls to this parent

_____ Is this a cell phone? Yes No
Primary Phone

_____ Is this a cell phone? Yes No
Secondary Phone

PARENT/GUARDIAN #2

_____ _____ _____
Relation to child | Last Name | First Name

_____ _____ _____ _____
Date of Birth | Social Security Number | Preferred Language | Preferred email address

Address_____ _____ _____ _____ _____
Number & Street | Apt # | City | State | Zip Code

☐ Reminder calls to this parent

_____ Is this a cell phone? Yes No
Primary Phone

_____ Is this a cell phone? Yes No
Secondary Phone

CHILDREN IN FAMILY IN ORDER OF BIRTH

_____ _____ _____ Male Female
Last Name | First Name | Date of Birth

_____ Hispanic/Latino _____ _____ _____
Race | No Yes | Primary Insurance | Subscriber (mom or dad) | Contract #/Member ID

_____ _____ _____ Male Female
Last Name | First Name | Date of Birth

_____ Hispanic/Latino _____ _____ _____
Race | No Yes | Primary Insurance | Subscriber (mom or dad) | Contract#/Member ID

_____ _____ _____ Male Female
Last Name | First Name | Date of Birth

_____ Hispanic/Latino _____ _____ _____
Race | No Yes | Primary Insurance | Subscriber (mom or dad) | Contract #/Member ID

_____ _____ _____ Male Female
Last Name | First Name | Date of Birth

_____ Hispanic/Latino _____ _____ _____
Race | No Yes | Primary Insurance | Subscriber (mom or dad) | Contract #/Member ID

If you have a secondary insurance for any child listed above, please list here:

_____ _____ _____ _____
Secondary Insurance | Subscriber | Contract # | Group #

EMERGENCY CONTACT INFORMATION

Please list the information for an emergency contact living outside your home.

Relation to child	Last Name	First Name	Phone Number
_____	_____	_____	_____

I have completed the Patient Registration and certify the information to be true and accurate to the best of my knowledge at the time of completion. Any changes to my information once this form is completed are my responsibility to update with the office, and will be kept up-to-date as best as possible.

Parent/Guardian Signature **_____**

Date Completed (office to complete) **_____**

STATEMENT OF FINANCIAL POLICIES

I have received a copy of and read the Statement of Financial Policies in effect as of this date and agree to abide by its provisions.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Kidz1st Pediatrics, PLLC to release any and all information that in their sole judgment is felt necessary for medical care or for any portion of the processing of a claim for the medical services rendered.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical and surgical benefits to Kidz1st Pediatrics for medical services rendered.

RECEIPT OF NOTICE OF PRIVACY RIGHTS

I acknowledge that the Notice of Privacy Practices for Kidz1st, PLLC will be available for me to read upon request, and its provisions apply to all the members of my family who seek medical care with Kidz1st, PLLC.

ACKNOWLEDGMENT OF IMMUNIZATION POLICY

I acknowledge that the Immunization Policy for Kidz1st, PLLC will be made available to me upon request and I will abide by its provisions if I wish for my child(ren) to remain patient(s) at Kidz1st.

Signature_____ Name (please print)_____ Date_____

STATEMENT OF FINANCIAL POLICIES

1) I agree to provide my child's current insurance card(s) at every visit, as well as a current driver's license or acceptable photo ID upon request. A copy will be kept on record by Kidz1st.
2) I understand that providing a valid credit or debit card is optional for Kidz1st to charge for any copay, or past due balance owed on my account. I am aware my card will be stored by Kidz1st in a secure manner, and that Kidz1st will notify me of any charge to my debit/credit card.
3) I understand that full payment for services rendered is expected at the time of service. In accordance with my health insurance contract, I agree to pay any co-pay at the time of service. **Any co-pay that is not paid at the time of service will incur a $10 service charge.**
4) I agree to pay a **$25 no-show/late cancellation service charge** if, regardless of cause, either a) I do not show for a well visit appointment, or b) I do not call Kidz1st at least 1 hour prior to the appointment time to cancel a well visit.
5) I understand that, in the event of financial hardship, I am be able to make alternative payment arrangements with the billing department. If the payment arrangement is not abided by, I understand my account may be turned over to an outside collection agency.
6) I understand that if, for any reason, I have a balance outstanding for 90 days or longer, my account may be turned over to an outside collection agency. If my account is turned over to a collection agency, I understand that I will be financially responsible for any charge that the collection agency requires in addition to my outstanding balance.
7) I agree to pay a service charge of $25 for each check returned for non-sufficient funds.
8) I understand that in certain instances, at the sole discretion of Kidz1st, I may be required to pay cash for services before the services are rendered.

Vaccine Policy Statement

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe in the effectiveness and safety of vaccines to prevent serious illness and to save lives.

We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data.

We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations.

Please be advised, however, that delaying or "breaking up the vaccines" to give one or two more at a time over two or more visits goes against expert recommendations. It is against our medical advice, and causes increased pain for your child.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death. In addition, if your child were to contract one of these diseases, they could spread it to other children too young to be vaccinated.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us