Avoyelles Pediatrics   Healthy Steps Pediatrics   Mansoor Pediatrics   Pediatrics on the Red

PATIENT INFORMATION:

Last Name: ____________________________ ***First Name:*** __________________________________ ***M.I.*** __________

Date of Birth: ___________________________________ ***Gender: ( )Male ( )Female***

Social Sec # (last four): ***-**____________ ***Race:*** __________ ***Ethnicity: ( )Hispanic ( )Non- Hispanic***

Mailing Address: ____

City: ____ ***State:*** __________________ ***Zip Code:*** _________________

Home Phone #: ( )___________________________ ***Cell Phone #: ( )***_________________________________

Email Address: ____ @______________________________

******Hospital patient was born at***________________________________***Natural***_____________ ***C-Section***__________

******Was the baby in the NICU: Yes or No*** ***Birth weight:***______________ ***Birth length:***______________

Insurance Information:

_____***Medicaid***

_____***Self-Pay***

Financial Guarantor: ______________________________________***Relationship:*** _____________________________

_____***Private Insurance: Policy Number:*** _______________________ ***Group Number:*** __________________

Policy Holders Name: ______________________________________ ***Relationship:*** ___________________________

Policy Holders Social Sec # _________________________________ ***Date of Birth:***__________________________

Parents Information: (Please complete for both parents)

____***Mother*** _____ ***Father*** _____ ***Legal Guardian***

Last Name: ____________________________________ ***First Name:*** __________________________________

Date of Birth: _________________________________***Social Sec # (last four): ***-*****_____________

Phone #'s: Home: ( ) ___________________ ***Cell :( )***_____________________***Work: :( )***_________________

Address (If different from the child): ____

City: ___________________________________ ***State:*** _______________ ***Zip Code:*** ___________________________

____***Mother*** _____ ***Father*** _____ ***Legal Guardian***

Last Name: ____________________________________ ***First Name:*** __________________________________

Daye of Birth:_________________________________ ***Social Sec # (last four): ***-*****_____________

Phone #'s: Home: ( ) ____________________ ***Cell :( )***___________________***Work: :( )***__________________

Address (If different from the child): ____

City: ___________________________________ ***State:*** _______________ ***Zip Code:*** ___________________________

Revised Form 06/27/2018

Release of Information/Care Consents:

Please list any person or persons that are authorized to bring your child to doctor visits or call inquiring about your child's care. Any person listed below will be able to stay with your child during the exam, accompany him/her to the Outpatient Lab if necessary and get information about the child over the telephone. The information will also be used to verify authorization of a patient 17 years of age or older to see the doctor unaccompanied.

Name: ___________________________ Relationship: __________________ Phone #: (   ) _________________

Name: ___________________________ Relationship: __________________ Phone #: (   ) _________________

Billing Consent:

_______(Initial)

I authorize the release of any medical or other information necessary to process a claim on my behalf. I agree to be fully responsible for all lawful debts incurred by myself or service received from Mansoor Pediatrics/Healthy Steps Pediatrics/ Pediatrics on the Red/ Avoyelles Pediatrics whether it is covered by my insurance or not.

Consent to Treat:

_______(Initial)

Permission is granted to the physicians, nurse practitioners and employees of any/all Mansoor Pediatrics clinics. To do such procedures as may be necessary to diagnose, treat, and care for the needs of my dependent minor child including but not limited to routine office examinations and laboratory procedures such as strep test, and throat cultures, urine studies, complete blood counts (CBC), hematocrits, bladder catheterization, removal of cerumen (ear wax), removal of foreign bodies, drainage abscess, medication injections, immunizations and treatment of skin lesions, warts, burns, and lacerations.

E-mail/Text Patient Portal Authorization:

By providing my email address and or phone number above, I am authorizing Pediatrics on the Red/ Mansoor Pediatrics/ Healthy Steps Pediatrics/ Avoyelles Pediatrics to communicate with me by email/text and allowed access to my child's medical health information through the patient portal.

_______(Initial) I understand that the use of my email/phone number is for my convenience, and that I am not obligated to communicate via email/text.

_______(Initial) I understand the inherent unsecured nature of e-mail/text and therefore accept the risk of using e-mail/text.

_______(Initial) I also understand that I am responsible for informing our office of any changes regarding my e-mail/phone number.

______(Initial) ***I DO NOT wish to provide an e-mail and or phone number***

Print Parent or Custodial Guardians Name: ____

Signature of Parent or Custodial Guardian: ____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that under the Health and Portability & Accountability Act of 1966 (HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

- ***Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.***
- ***Obtain payment from third parties.***
- ***Conduct normal healthcare operations such as quality assessments and physical certifications.***

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the addresses below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are required to agree to my requested restrictions, but if you do not agree then you are bound to abide by my restrictions.

Patients Name: ____ ***Date:*** _____________________________

Parent or Guardians Signature: ____________________________***Relationship:*** _______________________

***Office Use Only:* I attempted to obtain the necessary signature in acknowledgement on this**

Notice of Privacy Practices Acknowledgment but was unable to do as documented below.

Date: _____________________________ ***Initials:*** ___________

Reason: ____