Crazy About Kids Pulmonary Services

Patient Information

Name _____ DOB _____ Sex _____

Preferred Name _____ Contact Phone _____

Home Address _____ City_____ Zip _____

Primary Language _____ Race _____ Ethnicity _____

Primary Care MD/NP _____ Phone Number _____

Pharmacy _____ Pharmacy Number _____

Patient lives with Mom Dad Foster Care Grandparent Other _____

If Foster Child, name of Caseworker _____ Phone Number _____

Parent/Guardian Information

Name _____ DOB _____ Relationship to Patient _____

Home Address _____ City _____ Zip _____

Phone Home _____ Phone Cell _____

Name _____ DOB _____ Relationship to Patient _____

Home Address _____ City _____ Zip _____

Phone Home _____ Phone Cell _____

Primary Insurance

Insurance Company _____ ID/Policy _____

Group Name/Number _____ Policy Holder Name _____

Secondary Insurance

Insurance Company _____ ID/Policy _____

Group Name/Number _____ Policy Holder Name _____

I understand that it is solely my responsibility to ensure that I am aware of my medical benefits. I understand that I am responsible for any copayments, deductibles or co-insurances or any other amount that is left as an unpaid balance for services received but not covered under my insurance policy. I also understand that a fee of $75 will be assessed for appointments missed without a 24 hour advanced notice. I authorize direct insurance payments of my benefits from my insurance company to Crazy About Kids Pulmonary Services LLC.

Signature of Parent/Guardian _____ Date _____

The providers and staff of Crazy About Kids Pulmonary Services are here to take care of children. Our focus is on the medical, psychological and emotional health of your child – NOT legal issues involving divorce, separation, or custody agreements. That is why we ask you to read and agree to the following:

1. Either parent or legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the visit summary. ***Unless there is a court order in the child's record that restricts a parent's rights, please do not ask us to limit the other parent's involvement in your child's care.***
2. Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. ***We will collect payment due from the parent who brings the child to the visit.*** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
3. Both parents/legal guardians can sign a "Consent to Treat" form. This means other persons (like grandparents, nannies, etc.) are authorized to bring your child to our practice, and can consent for treatment during that visit. ***We will NOT be involved in any disputes regarding named individuals on your child's Consent to Treat form.*** Both parents/legal guardians can see who is named on each other's forms; however, we will not comply with requests to eliminate names on the other's form, unless instructed by the Court. Please refer these requests to your attorney.
4. Additionally, we will **not**:
   - Call the other parent for consent prior to treatment or inform the other parent whenever visits are scheduled.
   - Restrict either parent's/legal guardian's involvement in your child(ren)'s care, unless authorized by law.
   - Tolerate appointment scheduling/cancelling patterns of behavior between parents.
5. It is both parents' responsibility to communicate with each other about the patients care, office dates/visits and any other pertinent information relevant to the care of the child. Please do not ask our providers to call the non-attending parent following visits.
6. Should the issues that come between parents become disruptive to our practice or impede the care of children, we reserve the right to discharge your family from further treatment.

_____	_____	_____
Parent Signature	Parent Printed Name	Date

Acknowledgement signature is required on this form by <u>ALL</u> families regardless of your personal family situation.

Crazy About Kids Pulmonary Services

Consent for Electronic Communication

I hereby consent to receive the following information electronically:

Health Notifications	☐ Email	☐ Phone	☐ Text Message
Appointments	☐ Email	☐ Phone	☐ Text Message
Announcements	☐ Email	☐ Phone	☐ Text Message
Billing	☐ Email	☐ Phone	☐ Text Message

My preferred phone number is: _____

My preferred email address is: _____

This consent will be in effect until I have given written notice to change the above information.

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices. Upon my request I will receive a printed copy for my records.

Print Name of Patient: _____

Patient's Date of Birth: _____

Signature of Patient/Guardian: _____

Date: _____

Crazy About Kids Pulmonary Services

Consent to Treat

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Parent's/Legal Guardian's Name: _____

Parent's/Legal Guardian's Signature: _____

Name of authorized person (i.e. relative/nanny/ friend) who is bringing in my child to be seen:

_____

_____

_____

I hereby grant permission for the person(s) listed to bring my child into CAKP for medical treatment, obtain prescriptions, and allow in the performing of medical testing on my behalf. I understand that this permission is valid until I have given written notice to cease.