Physicians to Children & Adolescents

**Today's Date**: _____

## Patient Information

**Last Name**: _____ **First Name**: _____ **Birth Date**: _____

**Gender**: Male or Female **Social Security #**:_____

**Address**: _____ **Patient's Phone**: _____

**Race**: ☐ Caucasian (White) ☐African American ☐Hispanic Other: _____

**Ethnicity**: ☐ American ☐Guatemalan ☐Chinese ☐ Indian ☐ Japanese ☐ Latin ☐ American/Hispanic

☐Mexican ☐Other **Primary Language Spoken**: _____

**Preferred Contact Method**: ☐ Phone ☐ Mail ☐Portal (Portal is only for patient age 10 and under

## Parent(s) or Guardian(s) Information

**Relationship to Patient**: ☐ Mother☐ Father ☐Legal Guardian ☐Foster Parent ☐Other_____

**Last Name**: _____ **First Name**: _____ **Birth Date**: _____

**Address (if different from patient)**:_____

**Primary Phone**: _____ Work **Phone**: _____

**Email Address**: _____ **Employer**: _____

**Marital Status**: ☐Married ☐Divorced ☐Single ☐Widowed

**Relationship to Patient**: ☐Mother☐ Father☐ Legal Guardian ☐ Foster Parent ☐Other_____

**Last Name**: _____ **First Name**: _____ **Birth Date**: _____

**Address (if different from patient)**:_____

**Primary Phone**: _____ Work **Phone**: _____

**Email Address**: _____ **Employer**: _____

**Marital Status**: ☐Married ☐Divorced☐ Single ☐Widowed

I have received a copy of Bardstown Primary Care Notice of Privacy Practices.

Parent or Guardian Signature: _____ Date: _____

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## Insurance Information

**Guarantor (Person who is responsible for bill)**

Your Insurance company in not your guarantor; legal guardian is responsible for all balances not covered by insurance

☐Mother ☐ Father ☐Other_____

**Primary Insurance**: _____
**Policy Holder**: _____
**ID#:**_____
**Group:** _____

**Secondary Insurance:** _____
**Policy Holder**: _____
**ID#:**_____
**Group:** _____

1. I hereby authorize the release of any medical information for treatment, payment and healthcare operations. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my or my dependents account. I understand that if for any reason my account should be sent to collections, I may be responsible for that collection agency fee. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell line, landline, text number I provide, 2) any email address that I provide, 3)auto dialer systems, 4) voicemail messages, and other forms of communications.
2. I give permission for Physicians to Children & Adolescents to access my pharmacy benefits data electronically through RXHub.
3. I give permission for Physicians to Children & Adolescent to transmit immunization information electronically through Kentucky Health Information Exchange.

Parent or Guardian Signature: _____
Date: _____

**Financial Statement**

Your health insurance may not pay for the services provided in the office such as labs, vaccines, etc… Health insurers do not pay for all your health care costs; it is your responsibility to know your healthcare benefits. Some sets of vaccines may cost up to 800.00

By signing below you agree to take financial responsibility for the cost, if your health insurance does not pay for the services provided.
Parent or Guardian Signature: _____
Date: _____

Physicians to Children & Adolescents

**HIPAA/CONSENT TO TREAT**

We understand that it is not always possible to accompany your child during their office visits. It may be more convenient to have prior authorization in place, so that medical care including immunizations may be delivered to your child in your absence. This authorization will include a phone call to our nurse for medical questions/advice.

**If you choose not to pre-authorize treatment in your absence please be advised that a parent will be required to accompany the child at each office visit, unless other authorization is sent with your child.**

☐ I **do not** wish to pre-authorize Physicians to Children & Adolescents to administer care for my child in my absence. I understand that I must accompany my child at every visit unless other authorization is sent with my child.

☐ I authorize Physicians to Children & Adolescents to administer care to my child when accompanied by the individuals listed below. I understand that it is my responsibility to inform the office if this information should change.

| Name: | Phone: | Relationship to Patient: |
|---|---|---|
| 1._____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

**Preferred Lab:**

Some insurance companies require that your lab be sent to a specific company for processing. If your insurance company prefers a specific lab, please select below your preferred lab.

NOTE: All labs will be processed by Hardin Memorial under the following circumstances.

1. Labs that our physician needs immediate results
2. Patients with Passport Health Plan or Kentucky Medicaid
3. If you do not select a preferred lab below

☐ Hardin Memorial
☐LabCorp
☐Quest Diagnostic