Demographic Information

Suburban Pediatrics
Phone: (716) 565-9030 | Fax: (716) 565-9038
www.suburbanpediatrics.com

Ensuring the delivery of high-quality, patient-centered care requires understanding the needs of the populations served. In accordance with federal categories and definitions, insurance companies have adopted a policy that requires the collection and recording of race, ethnic background and language preference. Suburban Pediatrics understands the sensitive nature of this information and assures you that it is kept secure and confidential in accordance with all State and Federal privacy acts.

➢**PATIENT**

Patient Name: _____ **DOB:** _____

Patient's Birth Mother's Maiden Name: _____

Patient Lives With (Name): _____ **Relationship:** _____

Does this patient live with both parents? YES: _____ **NO:** _____*

*If **NO**, please provide the Name/DOB/Phone # of the other parent:

Name: _____ **DOB:** _____

Phone: (_____) _____ **Alt. Phone:** (_____) _____

➢**RESPONSIBLE PARTY**

Name: _____ **Primary Phone #:** (_____) _____

Address: _____ **Work Phone #:** (_____) _____

City/State/Zip: _____ **Alt Phone #:** (_____) _____

E-Mail Address: _____

Marital Status: Never Married · Married · Domestic Partnership · Annulled · Divorced · Legally Separated · Widowed
(**Please Circle**)

➢**PRIMARY PHYSICIAN**: _____

PRIMARY INSURANCE	
Plan Name:	
Policy #:	
Group #:	
Eff. Date:	
Subscriber:	

SECONDARY INSURANCE	
Plan Name:	
Policy #:	
Group #:	
Eff. Date:	
Subscriber:	

➢**EMERGENCY CONTACT**

Name: _____

Phone #: (_____) _____ **Relationship:** _____

➢**PLEASE ANSWER THE FOLLOWING 3 QUESTIONS (Circle Your Response):**

1. **Race**: White · Black/African American · Asian · Other (Please Specify): _____ Decline/Unknown
2. **Ethnicity**: Spanish/Hispanic Origin · Not of Spanish/Hispanic Origin · Decline/Unknown
3. **Primary Language**: English · Other (Please Specify): _____ · Decline/Unknown

➢I have reviewed the above information, and confirm it to be accurate. I understand that I am financially responsible for charges not covered by my insurance carrier if I fail to follow the policies set froth in my insurance plan, or if charges are denied because my insurance coverage is cancelled or not in effect at the time services are provided.

Parent/Guardian Signature: _____

OFFICE USE ONLY
Verified and entered: _____ _____
(Initials) (Date)

FAMILY MEDICAL HISTORY

Patient's Last Name_____ First Name _____

Date of Birth _____

Please complete the following with the name of consultants for this child.

Dentist: _____ Eye doctor: _____

Gynecologist _____ Other: _____

☐ **Check here if adopted.** ☐ **Check here if there has been no change in any family history.**

Please check the box for any changes in medical history pertaining to the mother, father, siblings, (MGM) maternal grandmother, (MGF) maternal grandfather, (PGM) paternal grandmother or (PGF) paternal grandfather.

	Mother	Father	Siblings	MGM	MGF	PGM	PGF
Allergies							
Asthma							
Attention Deficit Disorder							
Autism/developmental issues							
Blood disorders/hemophilia							
Cancer (please specify type)							
Cardiac conditions (ie. murmurs, strokes, hypertension (please specify)							
Diabetes (please specify type)							
High Cholesterol							
Kidney Disease							
Mental Health/Substance Use (please specify)							
Obesity							
Strabismus (lazy eye)							
Stomach Issues (ie. Celiac/Crohns/IBD) (please specify)							
Thyroid disease							
Any other family history							
Deceased (Age/cause of death, if known)							

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OFFICE USE ONLY

Reviewed/Entered: _____
(Initials) (Date)

Notice of Privacy Practices: Acknowledgment of Receipt

SUBURBAN PEDIATRICS, P.C.
Phone: (716) 565-9030 | Fax: (716) 565-9038
www.suburbanpediatrics.com

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Suburban Pediatrics, P.C. The Notice of Privacy Practices provides information about how the practice may use and disclose my protected health information.

The Notice of Privacy Practices is subject to change. If it is changed, a copy of the revised Notice will be posted in the office of Suburban Pediatrics, P.C. and I may request a copy at any time.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship

_____ _____
Name of Patient (if other than above) Date of Birth

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain Acknowledgement and the reasons why the Acknowledgment was not obtained.

_____ _____
Signature of Provider Representative Date

Patient Responsibility Agreement

SUBURBAN PEDIATRICS
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PATIENT NAME: _____

DATE OF BIRTH: _____

We request that you assist us with the following:

1. **Demographic Information**. It is your responsibility to provide accurate and up-to-date personal information to our office no less than annually, and also when any changes occur. Required demographic information includes a reliable residential address (not a P.O. Box) for the patient as well as reliable residential information for both parents if not residing at the same address; current telephone numbers for both parents; an emergency contact and telephone number of someone not residing with you; and a current reliable email address. An individualized form for each child is required.
2. **Insurance Information**. It is your responsibility to provide accurate and up-to-date medical insurance information and to notify us immediately of any changes in your insurance coverage. Please note that you are personally responsible for all charges incurred. To the extent that you fail to provide timely or accurate insurance information that results in non-payment for services, or your insurance denies coverage, you will be invoiced directly and payments are expected within 30 days.
3. **Payments**. You are responsible for, and expected to promptly pay all copayments, coinsurance payments, or unpaid deductibles at the time service is provided. The person bringing the patient in is responsible for payment. Failure to pay at the time service is provided will result in a billing fee of $15 to cover the cost of a statement being sent to you.
4. **Appointments**. We ask that you cancel any appointment you must change with at least 24 hour notification to our office. No-show appointments are very costly to everyone – we staff based on schedule needs and we can't see other patients who may need or want a visit at that time. Therefore, we have implemented a $50 charge for any visit not canceled with enough notice to use that appointment slot. This means that for each patient that does not come as scheduled, a $50 fee will be charged.
5. **Medical Care**. Our medical providers want to provide the best possible care for your child. There may be times when the standard of care or the physician's medical judgment determines that your child needs a service or test that may not be covered by your insurance carrier. The office will make every effort to notify you when we are aware of possible coverage issues. Unfortunately, we are unable to know which insurance carriers may deny services usually covered OR services that the physician or medical provider feels are necessary for your child. You agree to be responsible for payment of any/all non-covered services rendered by Suburban Pediatrics' physicians or medical staff.
6. **Forms**. We will provide each patient with a Health Assessment Form (HAF) at the end of their annual well visit. This form is good for one year from the date of the exam and can be used for most school, sports and camp activities. Any additional forms, special forms or motor vehicle accident forms will be completed at a charge of $10 per form.

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7. **Past-Due Accounts**. It is your responsibility to keep your account current with Suburban Pediatrics. A billing fee of $15 will be added to all accounts that must be re-billed. In addition, should your account remain unpaid, it will be flagged for non-payment and you will not be able to schedule appointments until arrangements have been made to clear your outstanding balance. Any account that remains unpaid past 30 days will accrue interest at the rate of 8% per annum.
8. **Collections**. If you fail to make any payment when due, Suburban Pediatrics reserves the right to refer your account to a third party for collection. You will be responsible for all costs associated with collection, including reasonable attorneys' fees.

FINANCIAL/PATIENT RESPONSIBILITY. I have read the above and understand and accept the terms of patient responsibility. I understand that, in the case of non-payment, I will be responsible for any and all collection fees and or attorneys' fees.

_____ _____

Parent/Guardian Signature **Date**

_____

Printed Name of Parent/Guardian

_____ _____

Witness **Date**