TWENTY FIRST CENTURY PEDIATRICS

6010 SOUTH ROUTE 53 SUITE D LISLE, IL 60532

6855 KINGERY HIGHWAY WILLOWBROOK, IL 60527

Please Fill out Completely

Patient Information

Last Name: _____ **Preferred Name/Nickname (if any):** _____

First Name: _____ **Date of Birth:** _____/_____/_____

Middle Initial: _____ **Primary Phone Number:** _____

Sex: ☐ Male ☐ Female **Contact Name/ Relationship:** _____

Home Address: **Secondary Phone Number:** _____

Street: _____ **Contact Name/ Relationship:** _____

Apt/Unit/ Building #: _____ **Email:** _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian 1

Relationship to Patient:

☐ Mother ☐ Father ☐ Guardian ☐ Step Parent ☐ Other (specify): _____

Last Name: _____ **Alt. Address (if different than patient):**

First Name: _____ _____

Date of Birth: _____/_____/_____ _____

Lives with Patient: ☐ Yes ☐ No **Email Address:** _____

Cell Phone Number: _____

Parent/Guardian 2

Relationship to Patient:

☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Step Parent** ☐ **Other (specify):** _____

Last Name: _____ **Alt. Address (if different than patient):**

First Name: _____ _____

Date of Birth: _____/_____/_____ _____

Lives with Patient: ☐ **Yes** ☐ **No** **Email Address:**_____

Cell Phone Number: _____

Insurance Information

Primary Insurance Carrier: _____ **Guarantor's Name:** _____

Subscriber ID: _____ **Relationship:** _____

Group ID # : _____ **DOB:** _____/_____/_____

Alt. Address (if different from patients): _____

~~☐ **Check if you have a secondary insurance. Please list:** _____~~

We will keep this information private and will update it in your child's medical record. Your answers are confidential. You may choose not to answer any questions if you prefer not to.

1. Are you Hispanic, Latino, or Spanish origin? (Mark ONE box)

   ☐ Yes (Specify- Mexican, Puerto Rican, Cuban, etc.) _____

   ☐ No, not Hispanic, Latino, or Spanish Origin

2. What is your race? (Mark one or more boxes)

   ☐ White/ Caucasian
   ☐ Black/ African American
   ☐ American Indian/ Alaska Native
   ☐ Asian
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ Some Other Race: _____ (specify)
   ☐ Prefer not to answer

3. What language do you feel most comfortable using with your healthcare providers and staff?
   ☐ English
   ☐ Spanish
   ☐ Another Language (specify): _____

Preferred pharmacy

Name of pharmacy: _____

Address: _____

Phone Number: _____

Thank you for choosing us for you or your child's healthcare needs. We are dedicated to providing high quality medical care and look forward to building a long-term relationship with you and your family.

Late Policy

Understanding that life is not always predictable and, in an effort to respect the appointment times of all of our patients, we have implemented the following late policy:

We have a 15 minute grace period. If you are running late, please contact our office to inform us and we will make every effort to accommodate you. If you are more than 15 minutes late you will be seen at the first available appointment time with the provider. If no appointments are available for that day then the provider will have you reschedule.

Minors

Anyone under the age of 18 must have a Parent/Guardian present for all appointments. If you are having someone accompany the patient during a visit then they will need to be at least 18 of age and we will need some form of consent stating who the patient is coming with – full name and relationship and that you, the Parent/Guardian, are approving it. Without a consent from the Parent/Guardian we will be unable to see the patient.

Payment

Co-payments are due at the time of your visit. Co-pays are for sick and follow-up appointments.

*This may differ depending on your insurance plan.

Insurance

Our office is committed to helping our patients maximize their benefits. Your insurance policy is a contract between you and your insurance company.

As a service to our patients, if you bring in all your insurance information, we will bill your insurance company. If you cannot provide us with necessary insurance information at the time of service or the insurance is showing inactive on our end then you will considered self-pay and payment will be expected to be paid in full the day of the appointment. If there is an issue with your insurance at that time you will need to bill your insurance for reimbursement.

You are responsible for any balance not paid over 90 days from date of service. It is your responsibility to provide our office with the current demographic and insurance information to ensure claims are being processed correctly.

It is the policy holder's responsibility to know the details of their insurance policy and the extent of coverage regarding **ALL** office visits. We cannot guarantee coverage of services or procedures provided due to the complexities of the insurance contacts.

Cancellation/ No Show

You will be charged a $25 fee for a cancellation fee if you cancel or do a no show to your scheduled appointment.

In order to provide you with high quality healthcare it is important for you to keep your scheduled appointment with the medical provider. Valuable time has been reserved for you or a family member. A missed appointment or late cancellation of an appointment results in lost time which could have been given to another person wanting to receive care. Every day we get many calls for appointments from both old and new patients. By cancelling your appointments as soon as possible, we can help other patients who are wanting to be seen.

Our office will try to call one day ahead and remind you of your appointment, however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment, please call 24 hours in advance. We have an answering service for your convenience if you decide to call after hours.

We realize emergencies may occur and you may not be able to notify us. We will discuss that situation with you when it happens.

With the medical care/needs of you and your family in mind we will be reassigning patients with three or more no shows to another provider to better accommodate those in need of same day appointments.

Medical Records

If at any time you need a full copy of records for yourself or to be faxed to another provider, etc there will be a $25 medical records release fee per patient that will need to be paid **BEFORE** processing any records. Once we have a filled out medical release form and the payment of $25, please give our office a minimum of 24 hours to get the request completed.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatments performed in this office. I understand and agree to this Financial Policy and Agreement.

Print name of patient

If minor – Print name of Responsible Party

Signature of patient/Responsible Party

Date

Refusal to Vaccinate Policy

Twenty First Century Pediatrics follow the immunization schedule approved by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices at the Centers for Disease Control (CDC).

As stated by the CDC:

- "Benefits of vaccination include partial or complete protection against infection for the vaccinated person and overall benefits to society as a whole. Benefits include protection from symptomatic illness, improved quality of life and productivity, and prevention of death."
- "Vaccines are recommended for members of the youngest age group at risk for experiencing the disease for whom efficacy and safety have been demonstrated."

As stated by the AAP:

- "Millions of children have been protected against serious illness because they were immunized. Most childhood vaccines are 90% to 99% effective in preventing disease. When a large majority of children have been vaccinated, it is expected that most get the disease will have been vaccinated. And if a vaccinated child does get the disease, the symptoms are usually milder with less serious side effects or complications than in a child who hasn't been vaccinated."

While we respect that your beliefs may differ from those of the staff at Twenty First Century Pediatrics, we cannot risk the health of our other patients or staff members due to unvaccinated patients who can spread diseases.

It is our priority that patients of Twenty First Century Pediatrics must begin their immunizations no later than two months of age or within two months from your initial visit. An alternative vaccine schedule must be discussed and agreed upon with your provider. Please be advised that if you choose not immunize your child, we will ask that you find a physician or provider that will accommodate your needs.

Thank you for understanding.

Consent for Release and Use of Confidential information, Receipt of Notice of Privacy Practices Form, and Billing Information

I, _____, hereby give my consent to Twenty First Century Pediatrics, LLC.

(Print Name of Patient/ Responsible Party)

to use, disclose, or release any medical information and copies of any medical records necessary to carry out treatment, process a related claim, or request payment of benefits directly to Twenty First Century Pediatrics, LLC.

I also authorize Twenty First Century Pediatrics, LLC. to release to my current and former insurance plans and any other physicians, any medical information and copies of medical records requested by those parties for the purposes including, but not limited to: Office visits, hospitalizations, lab/medical testing, or insurance chart reviews.

For the purpose of patient communication, I authorize that twenty First Century Pediatrics, LLC. has:

☐ No restrictions (e.g. May leave voicemails, send emails, etc. with medical results)

☐ Restrictions (e.g. Direct person-to-person communication with parent/guardian – cannot leaves voicemails, send emails, etc. with medical results)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me in the office or on the website.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

The insured/responsible party will pay for any fees applied to a yearly deductible or co-pay. The insured/ responsible party will also remit payment for any unpaid claims which are 60 days or more past due. It is the insured/responsible party's responsibility to know their individual insurance plan's benefits and the insured/responsible party agrees to pay all fees not covered by their individual insurance plan within 60 days of billing.

Name of Patient: _____

Patient/Responsible Party Signature: _____

If you are not the patient, please specify your relationship to the patient: _____

Date: _____