McKenzie Pediatrics

Today's Date: _____

Patient Information

Child's Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Soc Sec #: _____ Male □ Female □ Non-Binary □ Desire Patient Portal Access? Yes No

Is your child of Hispanic, Latino, or of Spanish origin? □ Yes □ No
If no, how would you describe your child? □ American Indian or Alaskan native □ Asian □ White
□ Black or African American □ Native Hawaiian or other Pacific Islander
What is your primary language? □ English □ Spanish □ Other: _____

Home Address: _____ City: _____State: _____ Zip: _____

Email Address: _____ Preferred Pharmacy: _____

RESPONSIBLE PARTY: (Name of person or persons responsible for this account)

Parent Name: _____Relationship To Patient: _____
Date of Birth: _____ Soc.Sec.#: _____Phone #: _____

Parent Name: _____Relationship To Patient: _____
Date of Birth: _____ Soc.Sec.#: _____ Phone #: _____

Whom May We Thank For Referring You To Us? _____

Emergency Contact (Other Than Parent): _____Phone #: _____

I authorize the following people to bring _____ in for treatment:
(Child's Name)
Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

INSURANCE INFORMATION:

Name of Insurance: _____ ID # _____

Secondary Insurance?: _____ ID # _____

(Please provide a copy of your current insurance card)

PLEASE TURN OVER FOR SIGNATURE

McKenzie Pediatrics, PC.
Office Policies

Our office policies represent our constant attempt to maintain fairness to each and every one of our patient families.

All OHP and OMAP Identification / Eligibility forms are required at "time of service". If you do not present this form you may be asked to reschedule the appointment.

Please give us **24-hour notice of any cancellation**, to allow for other patients to be scheduled in that appointment slot. A cancellation at the time of the appointment is considered by us as a "No Show" since we cannot use the time to see another patient in your place.

Once 2 appointments have been "**No-Showed",** you will receive a warning letter. After a **3rd "No- Show" appointment you may be terminated from McKenzie Pediatrics and asked to find another physician.**

Please remember that we care for many children at our office, and we strive to treat each child and family with **equal** consideration and respect.

_____

Credit Policy

Co-payments if required by your insurance are due at the time of service. Federal law requires that we not waive any patient co-payment, regardless of ability to pay, as this can be a form of discrimination.

We realize there are many families in a state of change. Our policy is that the parent or caregiver who requests treatment and brings the child in, will be responsible for payment (co-payment due at time service included) of services rendered.

Full payment is expected within 30 days of the service rendered unless otherwise arranged. If you are unable to pay your commitment within the 30 days of services rendered, **please** discuss this with our office staff to set up regular monthly payment arrangements. We reserve the right to impose a 1.5% service charge (or 18% annual rate) on any balance outstanding more than 90 days past service rendered. After 90 days, if you have not made specific payment arrangements, or have not made any payments, necessary collection proceedings will be initiated. Maximum credit limit is $500.

I consent to treatment. I authorize release of any information concerning my child's health care advice for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits payable direct to McKenzie Pediatrics, PC. Or Direct to the Physician.

I have read the above Office/Credit Policy, and agree to abide by its principles. I have also been given a copy of the Privacy Policy. Signature of Responsible party required:

Signature: _____ Today's Date: _____