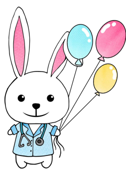

HEALTHY KIDS CARE
3196 S. MARYLAND PKWY, SUITE 411,
LAS VEGAS, NV 89109

PHONE: (702) 444-7685

PATIENT INFORMATION: **PLEASE PRINT (BLACK INK ONLY)**

Name:____ Date of Birth:___________Male:___Female:___Age:_______

Address:__________________________________ City:_____________________ State:_____ Zip Code:____________

Home Phone:___________________ Cell Phone:_______________________Work Phone:________________________

Employer:________________ Address:_______________________________ Social Security#: ______-______-_____

Ethnicity: __________________Emergency Contact: _________________________ Phone Number:_______________

PRIMARY INSURANCE INFORMATION:

Insurance Company:_______________________ Member ID:_______________________Group #:_______________

Claims Mailing Address:______________________________City:____________State:_____ Zip Code:____________

Name of Insured:_________________________ Relationship to Patient:______________________________________

Insureds Date Of Birth:_____________ Social Security #:_____-____-______Insurance Phone Number:_______________

SECONDARY INSURANCE INFORMATION:

Insurance Company:_______________________Member ID:_______________________Group #:_______________

Claims Mailing Address:______________________________City:____________State:_____ Zip Code:____________

Name of Insured:_________________________ Relationship to Patient:______________________________________

Insureds Date Of Birth:_____________ Social Security #:_____-____-______ Insurance Phone Number:______________

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I hereby authorize medical treatment for the above named patient and fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. **I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to HEALTHY KIDS CARE for any fees not covered by insurance.**

X_____ I understand that my insurance will be billed as a courtesy to me. I also understand that it is my responsibility to follow up with my insurance company 30 days from the date of service, to make sure they are processing my claims. Healthy Kids Pediatrics charges a 1.5% service charge per month for balances remaining unpaid after 45 days. Any claims not paid within 90 days will be my responsibility.
X_____ If I do not pay my copays or deductibles at the time when they are due or at the time of service, I understand that I will be responsible for an additional $10.00 administrative fee for each event, collection fees are additional.
X_____ In the event of default on any payments due to HEALTHY KIDS CARE., I agree to pay costs of collection, including attorney fees. I hereby authorize the filing of any insurance in force and the direct payment to HEALTHY KIDS CARE of any amounts on my claim. I further authorize the office of HEALTHY KIDS CARE and all pertinent medical records necessary to facilitate insurance billing or medical care and authorize the creditor or higher agent to make any employment or insurance verification and release of all information needed to process claims. I hereby authorize the office of HEALTHY KIDS CARE, to Receive, Mail, Fax, or E-mail my records to another physician or medical facility in the course of my diagnosis and treatment.
X_____ I also understand that I will be charged for an unexcused no-show or cancellation within 24 hours of my appointment time. I will be charged $25.00 for an unexcused no-show or cancellation within 24 hours of my appointment.

Signature:____Date:_____________
Acknowledgment **of Privacy Practices:** I hereby acknowledge that I have received a copy of this Notice Of Privacy Practices.
Signature:____Date:_____________