March 15, 2018

Midwest Child & Adolescent specialty group, P.C.

Dr. Maria Lily Vasco Dela Cruz
Dr. Pablito Dela Cruz

Patient:

Full Name: Nickname:

Date of Birth: Last 4 of SSN: Gender (Circle one): Male or Female Race: Ethnicity:

Religion: Primary Language:

Address: City: State: Zip: County:

Home Phone: ( ) Mobile 1: ( ) Mobile 2: ( )

Mother:

Full Name:

Maiden Name: Date of Birth: SSN (Last 4 acceptable):

Address: (SAME) City: State: Zip Code: County:

Home Phone: ( ) Mobile: ( ) Email:

Employer: Employer Address: Employer Phone:

Father:

Full Name:

Date of Birth: SSN (last 4 accepted)

Address: (SAME) City: State: Zip Code: County:

Home Phone: ( ) Mobile: ( ) Email:

Employer: Employer Address: Employer Phone: ( )

If child is NOT living with a parent, who is legal guardian?

Full Name: Phone: ( ) Relationship:

Address:

City: State: Zip Code: County:

Siblings: **Date of Birth:**

1.

2.

3.

Insurance Information

Primary Insurance Company:		
Policy Number:	Group Number:	
Subscriber's Name:	Date of Birth:	Employer:
Secondary Insurance Company:		
Policy Number:	Group Number:	
Subscriber's Name:	Date of Birth:	Employer:

- **Insurance Cards** need to be presented at every appointment so that we may verify eligibility. We ask that you notify us if coverage is lost or any health plan changes.
  _____ (Initial)
- **Co-payments** will be collected at time of service.
  _____ (Initial)
- **Non-covered Services** will be the responsibility of the guarantor or responsible party.
  _____ (Initial)
- **Self-Pay** patients will be offered a discount at *time of service* if office visit is paid in full. If full payment cannot be made at time of service the full amount will be charged.
  _____ (Initial)
- **Payment** plans are available upon request. We accept cash, personal checks, and most credit cards for payments. A returned check fee will be charged for returned checks, stopped payment, and/or closed account.
  _____ (Initial)
- **Collections** will be involved if an account is not paid in full or a payment arrangement is not made. The Guarantor is responsible for any expenses incurred in collection, including attorney fees and court costs.
  _____(Initial)
- **Failure to Pay/Keep Payment Arrangements** on balances may result in the office being unable to provide additional services.
  _____ (Initial)

Appointment/No Show Policies

- If an appointment cannot be kept, we ask that a parent/guardian call *before* the appointment time to either cancel or reschedule the appointment. If no notice is given before appointment time it is considered a ***No Showed*** appointment. Each patient is allowed up to six (6) no showed appointments before the family will be asked to leave the practice. There will be verbal notifications of missed appointments, then a final termination letter will be mailed.
  Once dismissed, a full year must pass before being considered for readmission.
  _____ (Initial)
- To decrease the wait period before appointments we ask that a child is checked in *no earlier* than 15 minutes.
  _____ (Initial)
- Arriving *late* to appointments delay the office and causes longer wait times. If a child arrives *later than 15 minutes* after the scheduled appointment time we will ask you to reschedule that appointment.
  _____(Initial)

Vaccination Policies

- Parents/Guardians are responsible for inquiring about the coverage of vaccinations with their insurance provider **PRIOR** to the appointment time. If vaccines are **NOT** covered by insurance, we require notice *before* the appointment, so arrangements can be made. If no notice given, Parents/Guardians will be responsible for any charges that are not covered.
  Our office does participate in the Indiana State Vaccine For Children program, which makes vaccines available to children without insurance or insurance that does not cover vaccinations.
  _____ (Initial)

- We feel that vaccinations are an important and life-saving part of raising healthy children, but we understand that some families choose not to vaccinate. We do offer a Delayed Schedule, and we also have a "Refusal to Vaccinate" form available upon request. Please notify the clinical staff if you choose to opt out of vaccinations or would like to use the delayed schedule. By opting out of vaccinations you acknowledge the risks associated with not vaccinating your child.
  _____(Initial)

Notice of Privacy Practices

I hereby acknowledge that I have received and reviewed the Privacy Practices of Midwest Child and Adolescent Specialty Group, P.C. and its subsidiaries, which sets forth the ways in which my and my child's protected health information may be used or disclosed by the office and outlines my and my child's rights with respect to such information.

_____

Signature of Parent/Guardian Date

_____

I have read, understood, and initialed all above policies and consent to treatment by Midwest Child and Adolescent Specialty Group, P. C. and its subsidiaries.

_____

Signature of Parent/Guardian Date

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Name: _____ Date of Birth: _____

The following consent gives Dr. Lily (and Staff) the ability to take photos of your child during your office visit. As you can see the pictures on the walls, she loves her babies! We have recently updated our website and Social media accounts, so some pictures might make it there too.

You may revoke this consent at any time and you may opt out of a specific use of the photo at your discretion.

CONSENT

(The term photograph includes video or photography, in any format, and any other means of recording or reproducing images)

- I hereby consent to my child being photographed while receiving treatment at Midwest Child & Adolescent Specialty Group P.C. _____ (initial)
- I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes: e.g., dissemination to Office staff, physicians, health professionals. Also, members of the public for educational, treatment, research, scientific, public relations, marketing, and **SOCIAL** media.

_____ (initial)

I Explicitly DECLINE consent to have my child Photographed _____(initial)

I wish for my child NOT to appear on Social Media _____(initial)

SIGNATURE

Date: _____

Signature: _____

(parent/guardian))

Print name: _____

(parent/guardian)

Disclaimer: We DO ask for you to respect our Physicians and Staff by NOT taking pictures/video of us without our permission and NOT posting our images on Social Media. _____(initial)

Emergency Contact/Consent

As the legal parent or guardian of _____ I hereby authorize the following person(s) to accompany my child to his/her appointment.

Name	Relationship	Phone Number
1.		
2.		
3.		

In my absence I give permission to the Providers to evaluate/treat my child._____(Initial)

I acknowledge that there may be labs and diagnostic tests to be performed._____(Initial)

If I have any question or concerns, I understand that I may contact your office._____(Initial)

In addition, I give consent for prescription pick up to the above identified individual(s).

Yes_____(Initial)

No_____(Initial)

_____

Print Full Name:

_____

Signature of Parent/Guardian Date