Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Legal Name_____ **DOB:**_____

Sex: M/F/T/Non-Binary **Nickname** (*if any*) _____

Address_____
Street City St Zip

Phone (____) _____-_____ **Email :** _____

INSURANCE INFORMATION

Primary insurance company name	Name of Policy Holder	Policy/ID Number	Group Number
Primary insurance company name	Name of Policy Holder	Policy/ID Number	Group Number

Emergency Contact:

Name: _____ **Phone Number:** (_____)_____-_____

Relationship: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly from my insurance company to the physician's of Great Destinations Pediatrics for Medical treatment(s) provided.
I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees, and all other costs.
I hereby authorize GDP to examine and treat me when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of myself.

FINANCIAL/OFFICE POLICY & HIPAA:
I have read and understand the foregoing financial and office policy and agree to abide by the terms of this policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule.

Responsible Party Signature Date

CONSENT FORM
Great Destinations Pediatrics, P.C.

Patient Name: _____ DOB:_____

Phone: (____)_____-_____

By checking the Abnormal/Normal boxes below you are giving permission to leave a voicemail or secure email for your test results if you cannot be reached at the time of the call.

Abnormal	Normal	
_____	_____	Primary Phone Number on File
_____	_____	Email: _____
_____	_____	Other Contact Name: _____ Relationship: _____ Telephone: _____

THIS CONSENT WILL BE VALID FROM _____/_____/_____ TO _____/_____/_____
(Today's Date) (Future Date)

I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE THE ORDERED TESTS DONE AND HAVE BEEN EXPLAINED THE IMPORTANCE AND REASONING FOR THE TESTING. I UNDERSTAND GDP CONTACTS ALL PATIENTS WITH NORMAL AND ABNORMAL TEST RESULTS AND IT IS MY RESPONSIBILITY TO CONTACT GDP IF I HAVE NOT RECEIVED THE RESULTS. THIS AGREEMENT WILL REMAIN IN EFFECT INDEFINITELY.
BY SIGNING THESE AGREEMENTS I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO INFORM GREAT DESTINATIONS PEDIATRICS OF ANY CHANGE OF INFORMATION.

_____ Date
Patient Signature

Great Destinations Office Policies

By signing this form, you understand and agree to the policies of Great Destinations Pediatrics. Our mission is the care of our patient is priority one, and that all patients be treated with respect and with the highest quality of care.

Financial Policy

Payments and Insurance Submissions

Great Destinations will submit claims and process payments with the insurance company on your behalf. Payment in full for accounts 60 days or older, not paid by the insurance company will be your responsibility. Non-insured, high deductible amounts are not yet met, and if coverage cannot be verified by the insurance company at time of service will need to pay for charges at the time of service. It is your responsibility to know what is covered versus not covered by your insurance plan.

_____ Initial

Returned Checks:

Great Destinations policy on **returned checks is a fee of $30.00** added to the account. The service charge must be paid in full in 3 business days by either cash or credit card. The patient's account will then be required to pay for all services by cash or credit card moving forward.

_____Initial

Appointments:

We require a 24-hour notice of cancellation prior to your scheduled appointment. Appointment time is scheduled for one patient, should you have more than one child needing to be seen a second appointment must be scheduled, we do not allow "add on's". If an appointment is missed and not canceled within the 24-hour timeframe a **fee of $25.00** will be charged to the account. Same day appointments must be canceled 2 hours prior to your scheduled appointment time to avoid the No Show Fee.

_____Initial

Medical Records/Requested forms:

All medical releases need to be submitted in writing using the Medical Release FROM/TO on the GDP website or obtained from the front desk and must be submitted by a parent or legal guardian. Medical records released to new PCP are free of charge. Vaccine records are provided free of charge. PHI (Personal Health Information - medical records) requested by a parent or legal guidance must be submitted in writing using the Medical Release FROM GDP form and received via mail, email, fax or drop off. PHI are required to be in either paper or electronic form, per parent or legal guardian's request. GDP will provide the electronic form for the PHI; no outside device will be used due to risk of security. Parent or legal guardian may request the PHI to be mailed, emailed, or faxed and understand the risk in transmitting private information through those various means and GDP is not liable for any security risks during transit. GDP has 5 business days to comply with this request that is submitted via email, fax, or mail. Walk in requests may take up to 10 days to process this request. A prepayment **fee of $25.00** is

required, as allowed through the HIPPA Privacy rule. Arizona state law states that a physician may charge a reasonable fee for medical records, per AZ statute 12-2295.

_____Initial

FMLA Forms:

If you are requesting the completion of FMLA forms you must email, fax, or drop off the form with your portion completed. Once the office has completed the form, it can be faxed or mailed to you, or any other party designated by you at time of request. A prepayment **fee of $25.00** is required. You may pay at the time of drop off or by calling the billing department at 623-878-2800 ext. 103.

_____Initial

If we feel any if the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge you from the practice.

_____Initial

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature (18 yrs. or older) **Today's Date**