Alamo Heights Pediatrics - Patient Demographic Info.

PATIENT: **(please complete ALL information requested)**

Legal Name :_____ **Male/Female** **Date of birth:**_____

SSN:_____ **Name Child Would Like to Be Called (if different from above):**_____

***Address:**_____ **City/State/Zip:** _____

Main contact phone #: _____ **Secondary phone #:** _____

In compliance with Federal HIPPA Privacy Regulations, will you authorize Alamo Heights Pediatrics to leave a detailed message on your answering machine/voicemail that may include appointment reminders, lab and x-ray results, referral information, and other private information protected by privacy rules?

Telephone Consent Authorization **YES or NO**

Parent 1 Name:_____ **Parent 2 Name:**_____

Address:_____ **Address:**_____

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

SSN:_____ **DOB:**_____ **SSN:**_____ **DOB:**_____

Employer:_____ **Employer:**_____

Primary Phone:_____ **Primary Phone:**_____

Siblings:

Name: _____ **Date of Birth:** _____ **Name:**_____ **Date of Birth:**_____

Name: _____ **Date of Birth:** _____ **Name:**_____ **Date of Birth:**_____

Name: _____ **Date of Birth:** _____ **Name:**_____ **Date of Birth:**_____

Authorized Family Members/Adults

It is the policy of Alamo Heights Pediatrics that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals, other than parents, are authorized to act in your place with respect to any and all medical matters. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

Name:_____ **Phone:**_____ **Relationship:**_____

Name:_____ **Phone:**_____ **Relationship:**_____

Name:_____ **Phone:**_____ **Relationship:**_____

Preferred Pharmacy Name/Location:_____ **Phone:**_____

Parent/Guardian/Self:_____ **Date:**_____

(Please complete BACK SIDE of form)

Responsible Party

Responsible Party is the individual who agrees to accept financial responsibility for the payment of all services performed at Alamo Heights Pediatrics. The individual may not necessarily be the insurance card holder. The responsible party must read and sign below.

Name:_____ Relationship to Patient:_____
Address (if different from above)_____ Social Security Number:_____
Primary Phone:_____ Email: _____

Payment for professional services is the responsibility of the accompanying parent/guardian at the time services are rendered. Co-pays and/or any deductible as well as all outstanding balances on the account are due upon check-in. As a courtesy, the office will file an insurance claim for reimbursement. It is the policy holder's responsibility to verify coverage under his or her policy, including co-pays and deductible provisions prior to any appointment. If for any reason the insurance plan declines to cover a service, it becomes the obligation of the parent/guardian to pay in full for such services. **There is a $20.00 fee charged for any appointment that is cancelled the same day it's scheduled for, or a no show will incur a $25.00 fee. Each consecutive No-Show after will increase by $5.00. After 3 consecutive on-time visits, we will reduce the no-show fee back to $25.00, this fee is not covered by insurance**. I hereby authorize this office to release my medical records to my insurance company for the purpose of filing claims. If a true patient credit remains on the account, we will mail a refund to the last known address to clear our accounting records. Please contact the office if you believe you have credit on your account after leaving this practice. We reserve the right to sever doctor/patient relationships if these terms are not met. I have read and agree to abide by this payment for services policy.

This authorization will remain in effect until changed or terminated by you or another individual/legal entity authorized to do so by court order or law submitting a written request to the Alamo Heights Pediatrics Privacy Manager in person or by mail to: Alamo Heights Pediatrics, 1919 Oakwell Farms Parkway, Suite 257, San Antonio, Tx 78218.

By signing below, I hereby acknowledge that I have read and agree to all terms and conditions of the office policies, demographic information and Notice of Privacy Practices provided by Alamo Heights Pediatrics.

Parent/Guardian/Self:_____ Date:_____

(revised 6/2023)