DATE_____ _____

**SUBURBAN PEDIATRICS, LTD.**
**INFORMATION SHEET**

## INSURANCE HOLDER'S INFORMATION

NAME_____ D.O.B_____

FULL ADDRESS_____

EMPLOYER_____ OCCUPATION_____

RELATIONSHIP TO PATIENT(S)_____

CONFIRMATION CONTACT#_____ ☐ MOTHER CELL ☐ FATHER CELL ☐ HOME

(PHONE# TO CONFIRM APPOINTMENTS)

2ND CONTACT#_____ ☐ MOTHER CELL ☐ FATHER CELL ☐ HOME 3RD CONTACT#_____

(OPTIONAL)

## OTHER PARENT'S INFORMATION

NAME_____ D.O.B_____

FULL ADDRESS_____

## CHILDREN'S INFORMATION

PLEASE INDICATE WHOM THE CHILDREN RESIDE WITH

NAME_____ D.O.B_____ _____

NAME_____ D.O.B_____ _____

NAME_____ D.O.B_____ _____

NAME_____ D.O.B_____ _____

**ETHNICITY(Check One)**

☐ Non-Hispanic
☐ Hispanic
☐ Refused to Report

**PRIMARY RACE (Check One)**

☐ White
☐ Hispanic
☐ African American/Black
☐ Asian
☐ Native American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Other Race
☐ Unreported/Refused

PREFERRED PHARMACY_____
NAME ADDRESS PHONE NUMBER

ELECTRONIC PRESCRIPTIONS: Our electronic medical records program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

IMMUNIZATIONS: Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your provider to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.

SIGNATURE_____ DATE_____
PARENT/GUARDIAN RELATIONSHIP TO PATIENT

## EMERGENCY CONTACT INFORMATION (NOT RESIDING AT THE SAME ADDRESS)

NAME_____ PHONE#_____

RELATIONSHIP TO PATIENT(S)_____

Do we have permission to contact this person regarding matters concerning the patient's care? Yes ☐ No ☐

**SUBURBAN PEDIATRICS, LTD**

## PAYMENT POLICY AND INSURANCE CLAIM SUBMISSION

Suburban Pediatrics, Ltd. is committed to providing you with the best care possible. If you have medical insurance that SPL is contracted with, we will help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and your understanding in adhering to our payment policy.

PAYMENT FOR SERVICES IS DUE AT THE TIME THE SERVICES ARE RENDERED, unless payment is arrangements have been approved in advance by the business manager. If you have a co-pay with your insurance plan, that, too, will be collected at the time services are rendered. Co-pays are expected every time SPL doctors or nurses perform services. We accept cash, checks, and credit cards (Visa, Mastercard, Discover & American Express)

We will also process all insurance claims on your behalf if you belong to any of the insurance networks that SPL is contracted with.

Please be advised that:

- Your insurance is a contract between you, your employer, and the insurance company. We are **NOT** involved with this contract.
- All co-pays must be paid in our office at the time services are rendered.
- Not all services are covered in all insurance contracts. Some insurance companies do not cover certain services. You need to find out and be aware that you will be responsible for the uncovered charges.
- We must at all times have a copy of your current insurance card. If you change insurance companies or policies, it is **YOUR** responsibility to notify SPL of these changes.
- In case of transferring out of our practice, it is YOUR responsibility to request a copy of your medical records. We will maintain possession of these records for ten years from the last date of service. A fee of $10 per child and a written authorization is required before records will be transferred.

We emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If payment problems arise, you must contact us promptly for assistance. If we do not hear from you, further action will be taken.

Authorization to release information and pay benefits to the physicians:

I hereby authorize directly to Drs Joyce, Graham, Arianas, Faron and Arsenault for medical benefits rendered and to release any information acquired in the course of my examination or treatment.
I have read all of the above and understand that I am responsible for payment to Suburban Pediatrics, Ltd.

_____ _____

Signature of Responsible Party or Spouse Date

**SUBURBAN PEDIATRICS, LTD**

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about your child may be used and disclosed, and how you can get access to the information. Please review it carefully and sign below.

I have read and understand the Suburban Pediatrics, Ltd. Notice of Privacy Practices.

Last Name: _____

First Name(s): _____

_____

_____

_____

_____

Signature of Parent/Legal Guardian/Legal Representative _____

**SUBURBAN PEDIATRICS, LTD**

**PRESCRIPTION MEDICATION CONSENT FORM**

The Providers of Suburban Pediatrics, Ltd use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information.

To optimize the use of this electronic capability, and coordinate your care between us and your specialists, we ask that patients allow us to access their medication history through the RxHub.

Please check one of the following:

☐ I consent to allow my provider to access all of my medication history.

☐ I DO NOT consent to my provider accessing any of my medication history.

_____
Printed Name

_____

Signature

_____
Date

Advocate Physician Partners

SynAPPs

## Specially Protected Health Information Authorization Form

Authorization to use and/or disclose protected health information in the Electronic Health Information Exchange.

____ Yes. I authorize this practice to use and/or disclose a copy of my protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access the eEHX to review my protected health information, including the following specially protected health information.

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdrawal permission my protected health information will be inactivated and the eEHX and will no longer be able to accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be continued on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

**PRINTED NAMES OF PATIENTS:**

_____ _____

_____ _____

**AUTHORIZATION OF REPRESENTATIVE:**

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient _____

_____ _____

Signature of Family Representative Date

# 24 Hour Appointment Cancellation Policy

Suburban Pediatrics, LTD. has a 24 hour cancellation / rescheduling policy.
**If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $50.**

This policy is in place out of respect for both our doctors and our patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. By signing below, you acknowledge that you have read and understand the Cancellation Policy for Suburban Pediatrics, LTD. as described above.

Thank you for your understanding and cooperation.

_____ _____
Print Patient's Name Print Patient's Name

_____ _____
Print Patient's Name Print Patient's Name

_____
Print Last Name

_____
Guarantor Signature

_____
Date