Date: _____

ADULT PATIENT DEMOGRAPHICS

This is a **YEARLY** form.
We are **required** to have **your** signature on file.

FULL NAME **DATE OF BIRTH** **GENDER**

_____ **___/____/____** **M / F/ Other**

Phone Number: (____) _____ Address: _____
Email: _____ City: _____State:_____ Zip :_____
SSN: _____ ***(This is REQUIRED for Insurance Purposes)***
Current School: _____ and/or Employer: _____

Who is allowed access to personal health information? *(make appts, pick up prescriptions, samples, letters etc.)*
Name: _____Relation: _____
Name: _____Relation: _____

I AUTHORIZE SPRING CREEK PEDIATRICS AND ITS STAFF TO DISCUSS MY MEDICAL INFORMATION WITH PARENT(S) and/or RELATIVE(S) LISTED ABOVE. ***Initial below***

- I allow access to my **diagnosis and treatment information: _____**
- I allow my **immunizations records** to be released by fax or mailed**:**_____ -
- I allow my **treatment plans** (i.e.: medication, asthma, epi-pens, etc.) to be disclose _____
- I allow my **office visits** to be accessed: _____
- I allow my **labs** to be released: _____
- With my consent, I allow any **"confidential information"** including results of **STD testing**, **HIV**, **AIDS**, and **Pregnancy testing** to be shared with_____ Parents/Relatives _____ Self Only

ANY CHANGES IN INSURANCE? YES/NO **If yes, please let front staff know*

EMERGENCY CONTACT
Name: _____ Phone Number: (_____) _____
Relation: _____

May we leave a message on your voicemail or text your cell phone regarding your appointment reminders, any test results, referral, account information etc. **YES / NO**

PLEASE REVIEW AND SIGN BACKSIDE OF DEMOGRAPHIC PAGE→

NOTICE OF PRIVACY

By my signature, I have been made aware of the SPRING CREEK PEDIATRICS' HIPAA Privacy Regulations. A synopsis of the manual is posted and available upon written request. A copy of the Federal Laws Governing the Protected Health Information (PHI) may be downloaded by going to https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

I understand that as part of my care, SPRING CREEK PEDIATRICS originates and maintains paper and/or electronic records describing my health history, symptoms, exams, test results, diagnosis, treatments, and plans for future care or treatment.
I Authorize the release of any office notes and results of images in the event it is needed to help with the diagnosis and plan of care for further treatment in coordination of care. I permit a copy of this information to be used in place of the original.

ACCOUNT INFORMATION

- For financial purposes, I allow **my parent(s)** access to discuss **my account**: _____ *(Initial)*

We are committed to providing the best care possible. Understanding your financial responsibility is considered part of your medical management. This Financial Policy is an agreement between you and the providers of SPRING CREEK PEDIATRICS. Your understanding is important to our professional relationship.

Though you may still be covered under your parent's insurance, **YOU**, as an adult, are solely financially responsible for any and all payments: copay, coinsurance or deductible that your insurance deems as your responsibility. You may meet with our Business Office for payment options and account changes.

It is your responsibly to provide SPRING CREEK PEDIATRICS with **accurate** and **timely** insurance information. Inaccurate or untimely information that results in denial or non-coverage by your insurance company will be your responsibly.

I acknowledge that during **my wellness visit**, there may be **a problem-oriented service** performed by SPRING CREEK PEDIATRICS provider. In this case, I understand that **two separate charges may be submitted** to my insurance and that **when applicable, a copay/deductible/co insurance may be required for charges generated pertaining to problem-oriented services.** Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my copay /deductible would still apply.

NON-EMERGENCY APPOINTMENTS may be rescheduled if your account has an outstanding balance(s) or if a co-payment is not paid at time of service. We accept cash, checks, MasterCard, AmEx, Visa, or Discover. Outstanding balances are due within 30 days, unless prior arrangements have been made with SPRING CREEK PEDIATRICS' BUSINESS OFFICE.

PATIENT CODE OF CONDUCT

This policy outlines the expected standards of conduct for **ALL** patients & family receiving care at SPRING CREEK PEDIATRICS to contribute to a **safe** and **positive** healthcare environment. **Respectful conduct is required;** treat **ALL** staff members with courtesy and respect. This includes; avoiding uses of **abusive**, **threatening**, or **discriminatory language** in **office** and on **phone** calls. **Form Completion; completion of forms is vital for you child(ren)'s care. Staff may hand out policy forms like: Divorce Policy, COB letter, Barto, Hoss & Company Information etc., In this instance it is YOUR responsibility to follow those guidelines.**

NO-SHOW POLICY

We understand that unforeseen circumstances may cause you to miss an appointment. We are able to cancel or reschedule appointments. **We ask that you call as soon as you are aware that you will not make your appointment**. **NO-SHOW** appointments interfere with the quality of care for ALL patients and can cause MEDICAID PATIENTS to lose their right to come to us per contract terms.

- A Warning Letter will be sent after 3 NO-SHOWs
- If a 4th NO-SHOW occurs you and your child(ren) will be discharged from our practice.

X _____ **Date: _____**
Signature

_____
Print Name

This form must be completed in FULL

Revised 07.2025