Spring Creek PEDIATRICS

Date: _____

PATIENT DEMOGRAPHICS

This is a **YEARLY** form.
Please add children who live in your household.
We are **required** to have **Parent** or **Legal Guardian's** signature on file.

	FULL NAME	DATE OF BIRTH	GENDER	
1.)	**_____**	**___/____/____**	**M / F/ Other**	**Pt's cell # if 16+ _____**
2.)	**_____**	**___/____/____**	**M / F/ Other**	**Pt's cell # if 16+ _____**
3.)	**_____**	**___/____/____**	**M / F/ Other**	**Pt's cell # if 16+ _____**
4.)	**_____**	**___/____/____**	**M / F/ Other**	**Pt's cell # if 16+ _____**

PRIMARY CONTACT/GUARANTOR *(Person Responsible for Payment)*
Name: _____ D.O. B ___/___/_____ SSN: _____ ***(Required by Insurance)***
Address: _____ APT#_____City:_____ State:_____ Zip:_____
Primary Phone: (_____) _____Email:_____
Relationship to patient? _____

SECONDARY CONTACT/OTHER PARENT
Name: _____ D.O. B ___/___/_____ SSN: _____*(Required by Insurance)*
Address: _____ APT#____City:_____ State:_____ Zip:_____
Primary Phone: (_____) _____Email:_____
Relationship to patient? _____

WHO DOES CHILD(REN) LIVE WITH? _____
If Divorced or Separated, who is the Custodial Parent? _____
PLEASE NOTE: LEGAL DOCUMENTATION WILL BE REQUIRED.

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

Names of Those (Non-Parent, Non-Guardian) who have permission to bring the Child(ren):
***If parent or legal guardian is not present OR if child is 16+, we still have to have verbal consent by phone to give vaccines.*
Name: _____Relation: _____
Name: _____Relation: _____
Examples., Grandparents, Aunts & Uncles, Family Friends, Nannies etc.

EMERGENCY CONTACT
(Person other than parents)
Name: _____ Phone Number: (_____) _____
Relation: _____

May we leave a message on your voicemail or text your cell phone regarding your child's 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 child's care, SPRING CREEK PEDIATRICS originates and maintains paper and or electronic records describing their 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 for my child. I permit a copy of this information to be used in place of the original.

ACCOUNT AND INSURANCE POLICY

Thank you for choosing SPRING CREEK PEDIATRICS to care for your child(ren). 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.

It is important for you to be an informed consumer who understands the specifications of your insurance policy (*e.g.*, vaccine and doctor visit coverage and referral/ authorization requirements for specialty care). Insurance plans vary considerably. We **cannot** predict or guarantee what part of our services will or will not be covered. 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 **child's 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 child's 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 of Parent or Legal Guardian

_____

Printed Name of Parent or Legal Guardian

Revised 05.2025

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

5.) _____ ___/____/____ M / F/ Other Pt's cell # if 16+ _____
6.) _____ ___/____/____ M / F/ Other Pt's cell # if 16+ _____
7.) _____ ___/____/____ M / F/ Other Pt's cell # if 16+ _____
8.) _____ ___/____/____ M / F/ Other Pt's cell # if 16+ _____
9.) _____ ___/____/____ M / F/ Other Patient's # if 16+ _____
10.) _____ ___/____/____ M / F/ Other Pt's cell # if 16+ _____

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