PEDIATRIC Urgent Care
A Whole New Way To Treat Your Child

Welcome to Little Spurs Pediatric Urgent Care!

Today's Date: **Please Provide a Photo ID**

Patient's Last Name: First: Middle: Patient's Gender: □ M □ F

Pt SSN: / / If 16 or Older: Emancipated?: Y N Patient Date of Birth: / / (mm dd yyyy)

Pt Age: Patient's Address: Apt # City: State: Zip:

Home Ph #: ( ) Cell #: ( ) Preferred Language:

Race: □ Am Indian/Alaska Native □ Asian □ Black/African Am □ White **Ethnicity**: □ Decline □ Hispanic/Latino □ Not Hispanic/Latino

RESPONSIBLE PARTY INFORMATION

Circle One: You Are The Child's: Mother Father Grandmother Grandfather Aunt Uncle Brother Sister

Your Last Name: First: Middle: Birth/Maiden Name:

Your Gender: □ M □ F Your SSN: / / Your Marital Status: S M W Sep Div Your Date of Birth: / /
Check here: O if address is the same as patient's (mm dd yyyy)

Your Address: Apt# City: State: Zip: Home Ph #: ( )

Cell #: ( ) Work #: ( ) Emergency Contact: Emergency Phone:( )

How Did You Hear About Us? □ MD Referral □ Internet □ Insurance □ Friend □ Print Ad □ Drive By □ School Other:

Have You Seen Us On The Internet? □ Yes □ No Parent E-mail Address:

INSURANCE POLICY HOLDER INFORMATION

Check Here for No Coverage ( )

INSURANCE POLICY # 1: **Name of Primary Insurance:** **Policy #**

Policy Holder Name: Gender: □ M □ F Relationship to Patient:

Marital Status: S M W Sep Div Date of Birth: / /
Check here: O if address is the same as patient's. (mm dd yyyy)

Address: Apt: City: State: Zip: Home Ph #: ( )

Employer: Employer Ph #: ( ) SSN: / / Cell #: ( )

INSURANCE POLICY # 2: **Name of Secondary Insurance:** **Policy #**

Policy Holder Name: Gender: □ M □ F Relationship to Patient:

Marital Status: S M W Sep Div Date of Birth: / /
Check here: O if address is the same as patient's. (mm dd yyyy)

Address: Apt: City: State: Zip: Home Ph #: ( )

Employer: Employer Ph #: ( ) SSN: / / Cell #: ( )

ASSIGNMENT OF BENEFITS FINANCIAL AGREEMENT HIPAA INFORMATION

I understand that charges are NOT final until the chart has been reviewed and the billing process is completed. In the event that the final balance on the account or invoice is a credit, the Practice has 30 days to notify the policyholder, guarantor or other responsible party by US Mail that a credit balance is on the account. In the event of no response to the notification, I authorize the credit to remain on my account and applied to any future services.

I authorize my insurance company to pay benefits directly to Little Spurs Pediatric Urgent Care, PLLC. I have read, understand, and agree to the Little Spurs Pediatric Urgent Care (The Practice) Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. In the event of my default, or non-payment of my bill, I agree to pay all collection costs, reasonable attorney's fees and court costs that may be added to the account as collection costs, in addition to the amount due for services rendered.

I acknowledge that Little Spurs Pediatric Urgent Care, PLLC, its' providers, owners and personnel have no control over how an insurance claim for services rendered is processed, considered, approved or denied by an insurance company or third party contractor, including whether or not a claim is in-network or out-of-network.

I authorize Little Spurs Pediatric Urgent Care providers and representatives to leave messages for lab results and other possible medical information at the phone numbers provided.

I hereby give my consent and authorization to The Practice, its' subsidiaries and its' practitioners to provide my medical treatment. If the patient is a minor, I, as custodian of the child, give my consent and authorization to The Practice, its' subsidiaries and its' practitioners to provide treatment for the minor patient. I understand that the physician, and/or nurse practitioner and/or physician assistant will explain my condition(s), foreseeable risks, and methods of treatment for the known condition(s) before treatment is provided. I authorize The Practice, its' subsidiaries and practitioners to perform any additional or different treatment(s) that is(are) necessary as deemed by the professional opinion of the Dr., NP or PA. Should a condition be discovered which was not known previously, I certify that I can be reached at the telephone # listed above in case of emergency, emergent test results, and/or further care is deemed necessary.

I authorize Little Spurs Pediatric Urgent Care, PLLC, to send e-mails to my e-mail address indicated above for business purposes such as surveys, announcements, events, articles, links, general medical information and marketing material. I understand that I can opt out of the e-mail program at any time by following the instructions to 'opt out'.

I authorize the release of my medical records, or in case of a minor, my child's medical records, to my primary care physician. This and any other subsequent authorizations to release Protected Health Information comply with the Privacy Practices Notice and Federal HIPAA regulations. I have been provided, or offered and declined, a copy of the Notice of Privacy Practices and Patient Financial Policies. I hereby authorize Little Spurs Pediatric Urgent Care, PLLC, and their healthcare providers to release all information necessary to my insurance company both when requested, or to facilitate the payment of my claim(s). I further agree that a photocopy of this agreement shall be as valid as the original.

As the person bringing the patient in, (the parent, the guardian and/or the custodian of the patient, or a person as allowed by Texas Law), I agree to be responsible for all services rendered to minor patients. I hold The Practice harmless for attempts to collect regardless of parental, guardian or custodial financial responsibility. I agree to be responsible for payment regardless of any divorce, separation or other outside agreements that may or may not be in effect at the time of service.

I have read The Practice Policies above regarding: Authorizations, Consents, Medical Records, Billing, Refunds, Guardian, Assignment of Benefits, Message, and email Marketing. I have read, understand and have been offered a copy of the posted Notice of Privacy Practices, the practice policies: 'Patient Financial Policy', 'Notice of Privacy Practices' and the 'Notice to Patients Regarding Credit Balance and Refunds' policies. I certify the information provided is true, correct and accurate.

X

Authorized Signature of Parent, Guardian, Custodian, Patient (if 18 or over) or Person With Patient Today **Relationship to Patient** **Date**