CHILDREN'S MEDICAL CENTER
Patient Information Sheet

PATIENT NAME: _____ Nickname:__ _____
Last First Middle

DOB:_____ Sex: ☐ Female ☐ Male Cell Number if teenager:_____

Race: (Please Choose One): ☐ American ☐ Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race ☐ Native Hawaiian/other Pacific Islander ☐ Other ☐ White ☐ Declined to answer

Ethnicity: (Please Choose One): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Answer

Primary Physician ☐ Markson ☐ Lashlee ☐ Zavadil ☐ Papadopoulos ☐ Ambardekar ☐ Chen-Becker ☐ Sweeney

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FATHER OF CHILD:

Name: _____
Last First MI

Date of Birth: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number:_____

Best Number to Call: ☐ Home ☐ Cell ☐ Work

Employer: _____

Occupation: _____

MOTHER OF CHILD:

Name: _____
Last First MI

Date of Birth: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip:___ _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number:_____

Best Number to Call: ☐ Home ☐ Cell ☐ Work

Employer:_____

Occupation: _____

Emergency Contact: _____ Relationship:_____Phone #:_____

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Other Child(ren) live(s) with ☐ Mom ☐ Dad ☐ other

Written Language of Family: _____ Spoken Language of Family:_____

Insurance: _____

Insurance ID Number: _____

Insured's Name: _____

Group Number: _____

OVER >

Family Medical History:____

____

Sibling's NAME: ____ Nickname: ________________________
Last First Middle

DOB:_______________ Sex: ☐ Female ☐ Male Cell Number if teenager:______________________________

Race: (Please Choose One): ☐ American ☐ Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race ☐ Native Hawaiian/other Pacific Islander ☐ Other ☐ White ☐ Declined to answer

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Last First Middle

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Last First Middle

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I have received a copy of the HIPPA agreement, and understand that personal information will be obtained to assist in accurate billing and collection. I understand that my insurance policy is a contract between the insurance company and myself and that Children's Medical Center is not a party to that contract. I am aware that some or all of the services provided may be nonA covered services for which I may also be billed. I authorize payment of medical benefits to physicians or suppliers of these services and all future claims. I also authorize the release of any medical information necessary to process this and all future claims.

Signature: ____ Date: ____________________________________

CHILDREN'S MEDICAL CENTER
Practice Limited to
Infants, Children and Young Adults
www.cmcpediatrics.com

1625 Marion Street
Denver, Colorado 80218
303-830-PEDS (7337)

Jay Markson, M.D., F.A.A.P.
Cecil H. Lashlee III, M.D., F.A.A.P.
Mary Zavadil, M.D., F.A.A.P.
Spyridon Papadopoulos, M.D., F.A.A.P.
Erin Ambardekar, MD, MPH, F.A.A.P.
Debbie Chen-Becker, MD, F.A.A.P.
Elizabeth Sweeney, MD, F.A.A.P.

FINANCIAL POLICY

Children's Medical Center's (CMC) mission is to serve all families in our community to the best of our ability and capacity. Due to the ongoing changes in the insurance industry and the vast number of differences in plan benefits, our office utilizes the information provided to us by you. We want you to be aware that any quote of benefits given to our office by your insurance company ***is not*** a guarantee of benefits or payment. All balances and current payments will be collected when you arrive at check in, unless a payment arrangement has already been established with our billing office, Western Skies, and is current. In order for the office to establish benefits correctly and assign appropriate patient balances, a copy of your insurance card is required. ***It is your responsibility to keep the office updated with your correct contact information including your address and phone numbers along with your insurance information*.**

- Payment is due at time of service; this includes deductibles and co-pays.
- Your financial responsibility to us will include co-payments, co-insurance, deductibles and any claim denials from your insurance company for all services rendered.
- The office offers a 20% prompt pay discount for all patients without insurance or services that come back not covered by your insurance.
- After exhausting internal attempts for payment, we will send delinquent accounts to our collection agency after ninety days. You will then be responsible for all costs incurred in collecting the balance. Should this happen, you risk being discharged from CMC, and the acceptance back into the practice would only be considered after your account is paid in full.

I have read and understand the Children's Medical Center Financial Policy and I agree to be bound by these terms.

_____ _____
Printed Patient Name and Date of Birth Date

_____ _____
Printed Signatory Name and Relationship to Patient Signature of Responsible Party

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information.

These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).** I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment for services rendered.
- The day-to-day healthcare operation of your practice.

I have also been informed or given a right to review or secure a copy of your Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to this restriction request. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Please print the names and dates of birth for all patients in family_____

_____

_____

Signature: _____

Relationship to Patient: _____

Date: _____

*Notice of Privacy Practices for Protected Health Information is available on the website www.cmcpediatrics.com or by requesting a copy from office staff.

Children's Medical Center No Show Policy

In order for our office to operate effectively and provide the best service for your children and family, Children's Medical Center is implementing a No Show Policy effective 10/1/14. If for any reason you are unable to keep your child's appointment, a parent/guardian must contact our office 24 hours before the scheduled appointment time. CMC will follow the following protocol for No Shows within a rolling 12 month period.

- First Occurrence: An attempt will be made to call patient's parent/guardian and remind them of the no show policy.
- Second Occurrence: An attempt will be made to call patient's parent/guardian and remind them of the no show policy.
- Third Occurrence: An attempt will be made to call patient's parent/guardian and a letter will be mailed to the address on file to inform of dismissal.
- Dismissal Means: CMC will provide acute care for 30 days until a new provider can be found and records are transferred. Dismissal will apply to all family members seen by the practice.

CMC is not responsible for inaccurate phone numbers and addresses. It is the parent/guardian responsibility to keep this information current with our office.

I have read and understand the CMC No Show Policy:

_____ _____

Patient, Parent or Guardian Signature Date

***Weekend Cancellations can be done by calling the office at (303)830-7337, by 5 p.m. Friday and pressing option #2.