2020

PALM PEDIATRICS

DR. ASHLEY C. BAYER, DO

# Information & Consent to Treat

*All information must be fully completed by the parent or guardian each year.*

| | Mother: (First, Middle and Last Name) | Father: (First, Middle and Last Name) |
|---|---|---|
| Name: | | |
| Date of Birth: | | |
| Social Security #: | | |
| Drivers License #: | | |
| Home Address: | | |
| | | |
| E-mail Address: | | |
| Home Phone #: | (  ) | (  ) |
| Cell Phone #: | (  ) | (  ) |

| | | |
|---|---|---|
| Emergency Contact: | Phone #: (  ) | Relationship: |

| | | |
|---|---|---|
| Subscriber Name: (Policy Holder) | | Date of Birth: |
| | Social Security #: | Phone #: (  ) |
| Insurance Company: | | Subscriber Phone #: |
| Insurance Company Address: | | Insurance Company Phone #: (  ) |
| | | |
| Member or Policy#: | Group #: | |
| Preferred Pharmacy | Location: | Phone #: (  ) |

| | Child(ren)'s Legal Name: (First, Middle and Last) | Sex | Date of Birth: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

- **I HEREBY AUTHORIZE THE ABOVE DOCTORS AND THEIR STAFF TO RENDER MEDICAL TREATMENT TO MY CHILD OR CHILDREN AS THEY DEEM NECESSARY.**
- I have received Palm Pediatrics practice policies, understand and accept them. I certify that the above information is accurate, complete and truthful.

Signed by: _____ Date: _____

Print Name: _____

PALM PEDIATRICS

DR. ASHLEY C. BAYER, DO

# EMERGENCY CONTACT INFORMATION

**LOCAL RELATIVE OR CONTACT TO NOTIFY IN EMERGENCY**

NAME:_____ RELATIONSHIP:_____

PHONE 1: _____ PHONE 2: _____

**EMERGENCY TREATMENT AUTHORIZATION**

I HEREBY AUTHORIZE THE ABOVE DOCTORS AND THEIR STAFF TO RENDER MEDICAL TREATMENT TO MY CHILD OR CHILDREN AS THEY DEEM NECESSARY IN THE EVENT OF AN EMERGENCY.

PARENT OR LEGAL GUARDIAN: _____

DATE: _____

**HOW DID YOU HEAR ABOUT US**

REFERRED BY: _____

**RETURNED CHECKS**

PLEASE BE ADVISED THAT THERE WILL BE A $30.00 SERVICE CHARGE FOR ALL RETURNED CHECKS FOR ANY REASON.

**ASSIGNMENT OF INSURANCE BENEFITS**

PHYSICIAN BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PALM PEDIATRICS OF PHYSICIAN BENEFITS.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I HEREBY AUTHORIZE PALM PEDIATRICS TO FURNISH ANY MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE IN ORDER TO PROCESS MY CLAIM. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDEDRED AS VALID AS AN ORIGINAL.
I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN(S) FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

INSURED PARENT OR LEGAL GUARDIAN: _____

DATE: _____

PALM PEDIATRICS
DR. ASHLEY C. BAYER, DO

# NEWBORN INSURANCE ENROLLMENT POLICY STATEMENT

Adding your newborn to your insurance policy is not automatic. **You, the insured, must call and initiate the addition of your new baby to your policy**, including the selection of Dr. Bayer as the child's pediatrician, also referred to as primary care physician, or PCP.

Insurance companies require you to enroll your newborn in your health plan within 30 days of your baby's birth. If your baby is not enrolled, your insurance plan will deny claims for your baby's care and **you will be responsible for full payment**.

- Contact the **EMPLOYER** that provides the insurance you will be using
- Fill out the necessary enrollment forms to notify the employer of the birth and add your child to the policy
- Submit these forms ASAP
- Call your **insurance company** member services department (the phone number is on the back of the insurance card) and:
    1. **Confirm** receipt of your forms
    2. **Confirm** enrollment of your newborn
    3. **Confirm** your choice of a PCP with your insurance
    4. **Request** all of your policy information, including the details of your coverage, benefits and limitations. These may include co-payments, coinsurance, deductibles and/or out-of-pocket expenses
    5. **Familiarize** yourself with policy coverage details and rules, exclusions, referral procedures that may result in patient financial responsibility.

If your baby is not added to the insurance policy within 30 days of their date of birth you will be financially responsible for all charges. It is the patient/parent's responsibility to bring to the office his/her insurance card and information. We are making every effort to keep down the cost of your medical care. **Please understand that you ultimately have the final responsibility of your bill.** If you are applying for Medicaid or Self-Funded coverage through the Marketplace payment is due at time of service until coverage is active. The office will issue you a detailed statement at which time you can submit to the insurance once active for reimbursement.

If you have any questions or concerns, please contact your insurance company immediately. **I certify that I have read the above policy statement and understand that I am responsible for my child's medical cost.**

Patient Name _____ Date of Birth _____

Signature of Parent _____ Date _____

PALM PEDIATRICS

DR. ASHLEY C. BAYER, DO



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

---

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

*Please print your name here*

_____

*Signature*

_____

*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

*Employee signature* *Date*

PALM PEDIATRICS

DR. ASHLEY C. BAYER, DO

# RELEASE OF MEDICAL INFORMATION

ATTN: MEDICAL RECORDS

DR. /OFFICE: _____ FAX: _____

ADDRESS: _____

_____ PHONE: _____

I hereby authorize you to release to Palm Pediatrics the medical records on my child/children named below. Please include all records of diagnoses, immunizations and significant problems for the duration of visits to your office from _____ to _____.

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP: _____

PLEASE FAX OR EMAIL TO:

EMAIL info@palmpediatrics.com

FAX 954.753.3104