2023

PALM PEDIATRICS

DR. ASHLEY C. BAYER, DO

Information & Consent to Treat

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

	Parent One: (First and Last Name)	Parent Two: (First and Last Name)
Name:		
Date of Birth:		
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: _____

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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: _____

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THE INFORMATION THAT FOLLOWS IS INTENDED FOR THE USE OF THE PERSON AND/OR ENTITY TO WHOM IT IS ADDRESSED. THIS INFORMATION MAY BE CONFIDENTIAL AND PRIVILEGED; THE DISCLOSURE OF WHICH IS GOVERNED BY APPLICABLE FEDERAL AND STATE LAWS. IF YOU ARE NOT THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, DISSEMINATION DISTRIBUTION OR COPYING OF THIS INFORMATION IS **STRICKLY PROHIBITED.**

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*

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We are committed to the highest level of quality care, in hopes to ensure minimum wait times, access to same day appointments, and adequate time with your doctor.
The below policies help us to continue our strive for excellence.

1. Cancellation/ No Show Policy for Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance, Palm Pediatrics reserves the right to charge a twenty five dollar ($25) fee; this will not be covered by your insurance company.

After a patient's third no show in one calendar year, Palm Pediatrics reserves the right to dismiss from the practice.

2. Scheduled Appointments/Walk-In Fee

We understand that delays can happen, however we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled time, we may be required to reschedule the appointment.

We recommend making appointments to ensure minimum wait times, access to same day appointments and adequate time with your doctor. If a walk-in visit is necessary, we will do our best to accommodate, however a walk-in fee of twenty-five dollars ($25) will be charged for a visit without an appointment. Additionally, a walk-in appointment is subject to variable and possibly longer wait times based on pre-scheduled appointments.

3. Account balances

We will require that patients with balances do pay their account balances to zero (0) prior to receiving further services by our practice. Copays and deductibles are due at the time services are rendered. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made. The office will bill your insurance as a courtesy to you, but it is your responsibility to make sure your child is covered for this visit.

Name	Signature	Date

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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