

**Families First Pediatrics
Patient Agreement/ Family Addition**

Name of Children	SS#	Sex	Date of Birth	Primary Care Physician
_____	_____	M F	_____	_____
_____	_____	M F	_____	_____
_____	_____	M F	_____	_____
_____	_____	M F	_____	_____

Father Name _____ Mother Name _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Phone _____ Cell _____

SS# _____ DOB _____ SS# _____ DOB _____

Employer Phone _____ Employer Phone _____

Employer _____ Employer _____

Emergency Contact other than immediate family _____ Phone _____

Relationship to Patient _____

How did you hear about our office? Friend/Family Hospital Mailer Phone Book Other

INSURANCE INFORMATION (PROOF OF INSURANCE IS REQUIRED)
(If proof of insurance is not available, patient will be considered not insured until proof is shown.)

Primary Insurance _____ Policy Holder _____ DOB _____

Address _____ Policy Holder SS# _____

City _____ State _____ Zip _____ Insurance ID# _____

Phone _____ Insurance Group# _____

Secondary Insurance _____ Policy Holder _____ DOB _____

Address _____ Policy Holder SS# _____

City _____ State _____ Zip _____ Insurance ID# _____

Phone _____ Insurance Group# _____

Please read carefully:

- Payment and/or copay is due at time of service. If copay is not paid at time of service a \$10.00 fee will be assessed to your account.
- I am responsible for knowing what my insurance does and does not cover. I am responsible for any unpaid balance after 45 days, regardless of insurance.
- If this account is assigned to an agency for collection, I/we agree to pay all attorney fees, with or without suit, court costs, and a collection fee of up to 40% of the balance, which will be added to the outstanding balance of my account.
- A \$25.00 fee will be assessed on all returned checks.
- I authorize care and treatment by Families First Pediatrics and release of all information to insurance and third party carriers and direct them to remit payment directly to Families First Pediatrics.
- Families First Pediatrics will not disclose medical information to anyone other than legal parent/guardian unless written authorization is provided.

Responsible Party Signature _____ **Date** _____

Printed Name _____ **Driver's License Number:** _____

Families First Pediatrics
PATIENT HISTORY

CHILD'S NAME: (Last, First, M) _____

Date of Birth: (mm/dd/yyyy) _____ **Race:** _____

(If the answer to a question is **YES**, please list proper information)

Medications:

What are your child's current medications?

Medication _____ Dosage _____
_____ _____
_____ _____

Are there any allergies to any medications? _____

Social History:

Is there smoking in this child's home? _____

Does this patient use tobacco, alcohol or other drugs? _____

Other: _____

Serious Illnesses:

Has this child had any serious illnesses in the past? _____

Has this child been diagnosed with Chronic Lung Disease? Yes No

Has this child been diagnosed with Congenital Heart Disease? Yes No

Does this child have a 'chronic disease' now? (diabetes, asthma, heart problems, etc) _____

Were there any abnormalities at birth? _____

Was there any problem during the pregnancy or delivery of this child? _____

Was this child born at or before 36 weeks gestation? Yes No

Is this child being treated any other physicians for any special problems at this time?

Name _____ Phone _____

Operations:

Has this child ever had surgery of any kind? _____

Has this child ever been hospitalized? _____

Allergies:

Family History: (i.e Cancer, diabetes, heart problems, etc)

Does this child attend day care? _____ Name _____ Phone _____

Consent For the Use and Disclosure of Protected Health Information

I hereby consent to the use and disclosure of my Protected Health Information by Families First Pediatrics/ FFP Management, LLC., their staff, and their business associates in order to carryout Treatment, Payment, or Health Care Operations. I understand that Protected Health Information means my health information which is individually identifiable (e.g. name, social security number, date of birth).

I understand that uses and disclosures for Treatment, Payment, or Health Care Operations include, but are not limited to:

- Using or disclosing health information in order to make a diagnosis or provide treatment to me,
- Submit health information to the health insurance company in order to obtain payment for treatment or services rendered,
- Share health information with other health care providers in which I have a treatment relationship, and
- Review my health information during quality assessment activities and training of medical personnel.

I understand that I have a right to receive a more detailed explanation of the Provider's privacy practices prior to signing this Consent. I also understand that the terms of the *HIPAA Notice of Privacy Practices* may change and that I may request a revised notice by contacting the person listed below and that a revised notice will be posted in the patient waiting area of the Provider's office.

I understand that I have the right to request that the Provider restrict how it uses and discloses my Protected Health Information in order to carry out Treatment, Payment, or Health Care Operations. I understand that the Provider is not required to agree to the restrictions, but that if the Provider agrees, the restriction is binding.

I understand that I have a right to revoke this Consent, but that I must do so in writing. I also understand that a revocation applies to the Provider's use and disclosures made after the revocation is made.

Signed: _____

Date: _____

Name (Print): _____

Patient Name: _____

Human Resource Department
Families First Pediatrics/FFP Management, LLC.
1268 West South Jordan Parkway, Suite #201
South Jordan, Utah 84095
(801)254-9700



Eligibility Screening Record

This record must be completed by the child's parent, guardian, or health care provider for children who receive immunizations through the Utah VFC Program.

Today's Date _____
 Month Day Year

Child's Name _____
 Last Name First Name Middle Initial

Date of Birth _____
 Month Day Year

Parent or Guardian's Name _____
 Last Name First Name Middle Initial

Health Care Provider _____

To be completed by health care provider

DATE SCREENED	VFC ELIGIBILITY* (Check only one category)					NOT ELIGIBLE
	ENROLLED IN MEDICAID	HAS NO HEALTH INSURANCE	AMERICAN INDIAN OR ALASKAN NATIVE	UNDER-INSURED	CHIP	INSURANCE COVERS VACCINATIONS**

*This record must be kept with the child's medical record. It may be used for all subsequent visits and updated as the child's eligibility status changes. Parents or guardians must be asked about eligibility status at each visit. Verification of a child's eligibility status is NOT required.

**Children with insurance, that has coverage for immunizations, are not eligible to receive VFC vaccines.

Patient Financial Agreement

Families First Pediatrics

1268 W. South Jordan Parkway, Suite 201

South Jordan, UT 84095

(801)254-9700

As the patient's financial representative, you understand and agree to the following:

- Payment and/or copay is due at the time of service. If copay is not paid at the time of service a \$10.00 fee will be assessed to the account.
- A \$25.00 fee will be assessed on all returned checks.
- You are responsible for the account balance after 60 days regardless of insurance coverage.
- You are responsible for knowing your insurance coverage and benefits. **It is your responsibility to make Families First Pediatrics aware of any charges not covered by your insurance, including all immunizations.** As a courtesy, Families First Pediatrics will bill your insurance and allow them 45 days to make payment. After 45 days it is your responsibility to follow up with your insurance.
- You authorize care and treatment by Families First Pediatrics and release of all information to insurance and third party carriers and direct them to remit payments directly to Families First Pediatrics.
- If your account is in good standing with no past history of collections or bankruptcy, Families First Pediatrics will extend credit on your account for a maximum of 6 months with a minimum monthly payment of \$50.00 or 1/6th of the account balance, whichever is greater.
- Accounts past 90 days will be charged interest at a rate of 1.5% monthly(18% annually). A late fee of up to \$20.00 per month may be charged to past due accounts.
- If the account is assigned to an agency for collections, it is agreed that the financial representative will pay all attorney fees, with or without suit, court costs, and a collection fee of up to 40% of the balance, which will be added to the outstanding balance of the account.
- Self pay patients will receive services at a discounted rate if charges are paid in full at the time of service. (The discounted rate will be between 20-30%)
- A notice of 48 hours for canceled appointments is appreciated. A \$25.00 charge may be assessed to the account if there is an excessive amount of missed appointments without notification.

Signature of Financial Representative: _____

Printed Name: _____ Date: _____

Drivers License Number: _____

Patient name(s): _____

Relationship to Patient: _____