Pediatric

South Alabama FAMILY CARE
Convenient Community Health Care

Patient's Name

_____

First **Middle Initial** **Last**

Date of Birth: _____ **Social Security #:** _____

Gender: Male or Female **Race:** _____ **Ethnicity:** Hispanic Non- Hispanic Other

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (**if different**): _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Mother's Name/Legal Guardian : _____

Date of Birth: _____ Previously seen at this clinic: Yes No

Primary Phone #: _____Secondary **Phone #:** _____

Preferred Method of Contact: _____ **Ok to leave Voice Message:** Yes No

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Father's Name/Legal Guardian: _____

Date of Birth: _____ Previously seen at this clinic: Yes No

Primary Phone #: _____Secondary **Phone #:** _____

Preferred Method of Contact: _____ **Ok to leave Voice Message:** Yes No

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Emergency Contact Name(other than listed above): _____

Phone #: _____Relation:_____

Preferred Pharmacy Information

Name: _____ Phone #: _____

Street/ City/ State: _____

Reason For Today's Visit/ Symptoms: _____

_____

Primary Care Physician: _____

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Name of Primary Office: _____

Primary Insurance: _____

Policy/ Contract/ ID #: _____ Group #: _____

Name of Primary Insured: _____ Relation to patient: _____

Primary Insured Date of Birth: _____ Social Security #: _____

Secondary Insurance (If Any):_____

Policy/ Contract/ ID #: _____ Group #: _____

Name of Primary Insured: _____ Relation to patient: _____

Primary Insured Date of Birth: _____ Social Security #: _____

I give permission for the following individuals **other than parent/legal guardian** listed on the above page to bring my child to South Alabama Family Care for medical treatment: **(Must also include emergency contact)**

Name: _____Relationship: _____

Name: _____Relationship:_____

Name: _____Relationship:_____

Financial Responsibility

Payment is due at the time of service. I understand I will be expected to pay any deductibles, co-payments, and fees at the time of any office related service. I will be responsible for any patient balances after insurance has been filed. I understand that South Alabama Family Care has the right to refer my account to an outside collection's agency after a period of 90 days. I hereby give authorization for payment of insurance benefits to be made to South Alabama Family Care for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In case of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare facility to release all information necessary to secure payment of benefits and that a photocopy of this agreement shall be as valid as the original

Initial: _____

Guarantor/ Financially Responsible Party

Check one: ☐ **Mother** (listed above) ☐ **Father** (listed above)

☐ **Other** Name: _____ Relation: _____

Mailing Address (**if different from patient**): _____

City: _____ State: _____ Zip Code: _____

Pediatric

Consent to Treat

I hereby give authorization to all the physicians and staff at South Alabama Family Care to treat myself and/ or my minor child. I understand that there are no guarantees regarding the result of treatment and/or examinations.

Initial: _____

Electronic Communications

SAFC, and/or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the email address you provide to use.

Initial: _____

Notice of Rights, Responsibilities, and Privacy- Summary

- SAFC can/will use my health information for the purpose of medical treatment, to obtain payment for treatment, and SAFC's health care operations.
- SAFC can/will also use and share my health information as required/permitted by law.
- I am responsible for following instructions about care and treatment and understanding the consequences if I do not follow them as directed by the clinical staff.
- I am responsible for giving complete and accurate information about my health and my medical history, as it is vital to my medical treatment.

Acknowledgement of Receipt for the Privacy Practices/ Patient Rights

I acknowledge that the South Alabama Family Care's Notice of Privacy Practices and the Patient Rights are posted for view in the lobby and listed above, and printed copy is available upon request from the front desk staff. The notice explains in detail my individual rights and how I may exercise these rights.

MEDICAL TREATMENT CONSENT FORM

The undersigned _____ do hereby authorize or such substitute as he/she

☐ Parent ☐ Guardian ☐ Other_____

may designate as agent for the undersigned to consent to any X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care for _____ which is deemed advisable

Minor's Name

by and to be rendered under the general or special supervision of any and/ or surgeon, licensed under the Provision of Medical Care Practice Act whether such diagnosis or treatment is rendered at the office of said physician, at a hospital, or elsewhere.

Patient's Complete Legal Name: _____

(Please Print)

Patient's DOB: _____ **Date:**_____

Signature: _____ **Witness:**_____

(Parent or Legal Guardian)