Patient Information

American Fork Pediatrics

Last Name	First Name	Middle	Birth Date	Sex	Race	Language
			____/____/____	M F		
			____/____/____	M F		
			____/____/____	M F		
			____/____/____	M F		
			____/____/____	M F		

Person to contact in case of an emergency (Not same address as the patient)

Name: _____ Phone Number: _____ Relationship to patient (s): _____

Children reside with (circle one): Mother Father Both Other: _____ Referred by: _____

*Email address for appointment reminders and updated office information: _____

Guarantor Information

Name: _____ Date of Birth: ____/____/____ SSN: _____

Address: _____Apt#_____City:_____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Name of other Parent: _____ Date of Birth: ____/____/____ SSN: _____

Address (if different from above):_____Apt# _____City:_____

State: _____ Zip:_____ Home Phone:_____ Cell Phone: _____

Insurance Information

Primary Health Insurance Name:_____ Policy Holder Name:_____

Policy or ID #:_____ Group/Name #:_____

Ins. Address: _____ City: _____ State: _____ Zip: _____

Ins. Phone: _____ Effective Date of Coverage: __/__/__ Visit Co-pay $_____

Secondary Health Insurance Name: _____ Policy Holder Name:_____

Policy or ID #:_____ Group/Name #:_____

Ins. Address:_____ City:_____ State:_____ Zip:_____

Ins. Phone: _____Effective Date of Coverage: __/__/__ Visit Co-Pay $_____

Office Policy Agreement

I authorize the care and treatment by Dr. Michael D. Whiting, M.D. and his associates. I also agree to the following terms: 1) I understand that I am responsible for my payment, my insurance is NOT responsible. 2) I understand that payment is due at time of service and hereby agree to pay my account as services are provided. 3) I understand that Dr. Michael D, Whiting, M.D. may bill my insurance as a service, but after 60 days I am responsible for payment in full. 4) I understand that co-payment is due at time of service. If co-payment is not paid at time of service, I agree to a $2.00 per month billing fee in addition to my co-payment. 5) If payment is not received from either my insurance company or the family within 60 days, I agree to pay 1.5% interest per month, minimum $2.00 per month (18% annual interest) on all unpaid balances exceeding the 60 days. 6) I agree to pay any legal and/ or collection fees that accrue to my account if I fail to pay, and collection activities or services are required. 7) I authorize release of all information to insurance or other third party carriers and direct them to remit payment directly to the doctor who provided the care. 8) I understand that I may be charged a service charge if I fail to keep a confirmed, scheduled appointment or an appointment make the same day that it was called for. 9) I understand that regardless of who brings in the child, I am responsible for payment the day of service (the Doctor CANNOT bill a THIRD PARTY such as an ex-spouse).10) I understand that I, or one of the child's parents must authorize treatment for each visit of our child. If a parent cannot attend an appointment, I will send a written authorization for treatment. 11) I understand that a $20.00 returned check fee will be charged on all returned checks.

Signature: _____ **Date:** _____/_____/_____

Print Name: _____**Relationship to patient (s):** _____

HIPPA Notice of Privacy Practices

I acknowledge that I have received a copy of American Fork Pediatrics' HIPPA Policy and that it is my responsibility to read said notice to understand how my children's Medical Records may be used. I understand that no authorization is required from me in order for American Fork Pediatrics to use my children's Medical Records for purposes of treatment, payment, or health care operations.

Signature: ____ Date: _____________