Instructions for the Completion of our Paperwork

Our patient registration form can be filled in by typing the information into the form. After you type in the information, print out the entire New Patient Registration Packet and complete the other forms by hand and bring them to your appointment with you.

Our hope is that this will be a much more convenient way to complete the needed paperwork prior to your visit.

Thank you.
VILLAGE PEDIATRICS
PATIENT REGISTRATION FORM

FILE CHARGES TO: ☐ HEALTH INSURANCE ☐ SELF PAY

HOME PHONE NUMBER (INCLUDING AREA CODE) ____________________________________________

ADDRESS: ________________________________________________________

NO POST OFFICE BOXES PLEASE

CITY: ________________________ STATE: ______ ZIP: ______

Which of our doctors do your children see? ____________________________________________

| LIST ALL CHILDREN HERE THAT ARE PATIENTS OF VILLAGE PEDIATRICS |
| ________________________________________________________________ |
| FIRST NAME | MIDDLE | LAST NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

☑ Male ☐ Female

☑ Male ☐ Female

☑ Male ☐ Female

☑ Male ☐ Female

☑ Male ☐ Female

MOTHER’S INFORMATION

MOTHER’S NAME ________________________________

SOCIAL SECURITY NUMBER: ____________________ EMERGENCY CONTACT __________________

EMPLOYER NAME: ____________________________ DAY PHONE NUMBER: __________________

DATE OF BIRTH _________________________ CELL PHONE NUMBER __________________

EMAIL ADDRESS (IF YOU WISH TO PROVIDE) ________________________________

FATHER’S INFORMATION

FATHER’S NAME ________________________________

SOCIAL SECURITY NUMBER: ____________________ DAY PHONE NUMBER: __________________

EMPLOYER NAME: ____________________________

DATE OF BIRTH _________________________ CELL PHONE NUMBER __________________

EMAIL ADDRESS (IF YOU WISH TO PROVIDE) ________________________________
GUARDIAN INFORMATION (ONLY IF OTHER THAN PARENTS)

GUARDIAN’S NAME

SOCIAL SECURITY NUMBER: ________________________ DAY PHONE NUMBER: ________________________

EMPLOYER NAME: ________________________

DATE OF BIRTH ________________________ CELL PHONE NUMBER ________________________

EMAIL ADDRESS (IF YOU WISH TO PROVIDE) ________________________

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INSURANCE INFORMATION

********** YOU MUST PROVIDE YOUR INSURANCE CARD(S) AND PHOTO ID TO COPY **********

PRIMARY INSURANCE

INSURED NAME: ________________________ RELATIONSHIP: ________________________

EFFECTIVE DATE OF COVERAGE ________________________

ID NUMBER: ________________________ GROUP NUMBER: ________________________

CLAIMS MAILING ADDRESS: ________________________

CITY: ________________________ STATE ________________________ ZIP: ________________________

SECONDARY INSURANCE

INSURED NAME: ________________________ RELATIONSHIP: ________________________

EFFECTIVE DATE OF COVERAGE ________________________

ID NUMBER: ________________________ GROUP NUMBER: ________________________

CITY: ________________________ STATE ________________________ ZIP: ________________________

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ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Village Pediatrics. I understand that I am financially responsible for all the charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney’s fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree that a photocopy of this agreement shall be as valid as original.

PARENT SIGNATURE: ________________________ DATE: ________________________

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AUTHORIZATION AGREEMENT

I authorize the release of my medical records as needed to any physician, facility or other provider of services that Village Pediatrics asks to participate in my medical treatment.

PARENT SIGNATURE: ________________________ DATE: ________________________

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CONSENT TO TREAT

I, the legal guardian/parent, consent for ________________________ to receive medical evaluation and treatment at Village Pediatrics.

SIGNATURE ________________________ DATE ________________________
VILLAGE PEDIATRICS, LLC
FINANCIAL POLICY

We thank you for choosing Village Pediatrics, LLC for the care of your children and we will strive
to provide the very best care. In order to do so, this document has been prepared to acquaint
you with our financial policies.

In order to better serve your needs, our office accepts numerous insurance plans, and every
plan is different. It is up to the insured to know the exact requirements of their own insurance
plan. In order for us to file insurance claims on your behalf, you must present active proof of
insurance at the time of your child's visit to our office. Insurance information must be provided
for each of your children. If you are not able to provide proof of insurance you must either pay
in full at the time of service or you may choose to reschedule your visit. Newborn parents, you
only have 30 days to sign your infant up for coverage. If you do not provide us with the proper
information within 30 days we will bill you for any services from birth on and your insurance
company will deny those claims making you responsible.

We will assist you in dealing with your insurance plan regulations: however, we will not be
responsible if you do not follow the specific terms of your insurance agreement. Your benefits
have been set according to your contract terms, and we must follow those terms exactly.
Please do not ask us to provide services outside those terms, or to file your claims in any other
manner, as we cannot do so. If you participate in an HMO and your card indicates that we are
not your provider and you cannot provide proof that you have changed to our practice, you will
be responsible for payment in full at the time of service.

We will be more than happy to file all insurance claims for you. However, when appropriate, if
your insurance company hasn't responded within 45 days, full and prompt payment will be
expected from you. If your insurance indicates that any service is a non-covered service you
will be responsible for that amount. Please do not ask that those services be written off as they
are deemed medically necessary and you will be billed.

Fees due at the time of service include: insurance copays, deductibles, non-covered services or
patients that are not covered by insurance. For your convenience we accept cash, check,
Mastercard, Visa, Discover and American Express.

Our office will do whatever we can to assist you. If you have any questions or problems, please
do not hesitate to contact our billing office at 913-642-2100, option 4, Monday-Friday 9:00-
3:00pm.
Signed__________________________________________ Date________________
VILLAGE PEDIATRICS

With my consent, Village Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Village Pediatrics’ Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Village Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Village Pediatrics Privacy Officer at 8340 Mission Rd., Suite 100, Prairie Village, Ks. 66206.

With my consent, Village Pediatrics may call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my child/children’s clinical care, including results among others.

With my consent, Village Pediatrics may mail, text message to my home or phone or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Village Pediatrics may e-mail to me appointment reminder cards and patient statements. I have the right to request that Village Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Village Pediatrics’ use and disclosures of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Village Pediatrics may decline to provide treatment to me.

______________________________
Signature of Patient or Legal Guardian

______________________________
Patient’s Name

______________________________
Date

______________________________
Print Name of Patient or Legal Guardian
VILLAGE PEDIATRICS, L.L.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

PLEASE CHECK ONE

☐ I, ____________________________, have received a copy
   (PATIENT)

☐ I, ____________________________, refuse to accept a copy
   (PATIENT)

_________________________________________  _____________
Signature of Patient                           Date
VILLAGE PEDIATRICS
8340 MISSION RD., SUITE 100
PRAIRIE VILLAGE, KS 66206
PHONE: 913-642-2100  FAX: 913-642-2127

THIRD PARTY FAX AUTHORIZATION FORM

PATIENT NAME: _______________________________________

DATE OF BIRTH: _____________________________________

1. I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL’S HEALTH
   INFORMATION DESCRIBED BELOW, BY FAX.

2. THE TYPE OF INFORMATION TO BE DISCLOSED IS AS FOLLOWS:
   (PLEASE CHECK MARK APPROPRIATE INFORMATION)

   ○ IMMUNIZATIONS RECORDS
   ○ LIST OF ALLERGIES
   ○ MEDICATION LIST
   ○ OTHER (PLEASE DESCRIBE)
   ○ ALL REQUESTS ___________________________________

I UNDERSTAND THIS AUTHORIZATION WILL REMAIN IN MY CHILD’S CHART UNTIL THEY ARE NO
LONGER A PATIENT OF VILLAGE PEDIATRICS, LLC

__________________________________________  ________________
SIGNATURE                                         DATE
Patient Name: ___________________________ M/F Date of Birth: ___________ Today’s Date: ___________

Race/Ethnicity: (Please circle) Caucasian Black Asian Hispanic Other

What language(s) is/are spoken in home?

Who does the child live with? (Include name and relationship of all persons in household)

Who has legal custody of the child?

Allergies: Please list
  Food:
  Drug:
  Environmental:

Current Medications:

Birth History: Delivery type (please circle): Single Twin Triplet Other
  Vaginal C/Section Other

Where was the patient born?
Were there any problems at birth? Yes/No
If Yes, Please list:

Past Medical History: Please check any that apply to your child.

  ADHD
  Allergic Rhinitis (seasonal allergies)
  Anxiety
  Asthma
  Bedwetting
  Bronchiolitis
  Concussion
  Constipation
  Crossed Eyes
  Depression
  Eczema
  G6PD
  Migraines
  Multiple Ear Infections
  Preterm Infant
  Reflux
  Seizures
  Sickle Cell Anemia
  Urinary Tract Infections
  Other ____________________

None
Surgical History: Please check any that apply to your child.

- Adenoids Removed
- Appendix Removed
- Circumcision
- Hernia Repair
- Hypospadius Repair
- Ear Tubes
- Pyloric Stenosis Repair
- Strabismus Repair
- Tonsillectomy
- Other (please list)__________________
- None

Family History: Please check the conditions that occur in any relative.

- Indicate the relationship: mother(M), father(F), brother(B), sister(S), mother’s mother(MM), mother’s father(MF), father’s mother(FM), father’s father(FF), aunt(A), uncle(U)

- ADHD
- Alcoholism
- Allergies (seasonal)
- Anemia
- Anxiety
- Arrhythmia
- Asthma
- Celiac Disease
- Congenital Hip Dysplasia
- Crohn’s Disease
- Cystic Fibrosis
- Depression
- Diabetes, Type I
- Drug Allergy
- Eating Disorder
- Heart attack (less than 55 yrs old)
- High Blood Pressure
- High Cholesterol
- Hypothyroidism
- Learning Disability
- Leukemia
- Migraine
- Seizures
- Sickle Cell Anemia
- Sickle Cell Trait
- SIDS (sudden infant death syndrome)
- Diabetes, Type II
- Ulcerative Colitis
- No Significant Family History
- Other (please list)__________________________________________

Please list any chronic problems, developmental concerns or any issues that should be noted in the patient’s chart:

Form filled out by (name and relationship to patient):
Date:
Village Pediatrics, LLC

No Show and Appointment Cancellation Policy

Village Pediatrics is committed to providing all of our patients with exceptional care. When a patient does not show for a scheduled appointment or fails to cancel without giving enough notice, they prevent another patient from being seen.

Please call us at 913-642-2100 at least 24 hours ahead of your appointment with any changes or cancellations. If prior notification is not given you will be subject to a charge.

By signing below, I state that I have read and understand the above policy.

______________________________  _____________
Parent/Guardian Signature      Date