

Platte County Pediatrics
1104 Platte Falls Road Platte City, MO 64079

PLEASE COMPLETE ENTIRE FORM AND PRINT CLEARLY

TODAYS DATE: _____

Patient's Name(s): _____ DOB: _____ Male ___ Female ___

Address: _____ City: _____ State: _____ Zip: _____

☐ Home Phone: _____

Please indicate which number to call for appointment reminders

☐ Cell Phone: _____

Parent or Legal Guardian:

Name: _____ Birth date: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Employer: _____ Work Phone: _____

Insurance Information: A copy of your insurance card must be on file to submit to Insurance

Primary Ins: _____ **Subscriber's Name:** _____

Subscribers DOB: _____ **Subscriber's Address** _____

(If different from above)

Policy # _____ **Group#** _____

(If patient has Tricare please put the subscriber's social security number.)

Secondary Ins: _____ **Subscriber's Name:** _____

Subscribers DOB: _____ **Policy #** _____ **Group#** _____

Preferred Pharmacy _____

Consent to Treat

I understand it is policy of this clinic to have a parent or legal guardian present when patients under the age of 16 are examined or treated. If I am unable to bring my child, I understand I must have written authorization to treat sent with the adult that brings my child, or have one of the individuals listed below bring the child in. I consent to have the above named patient(s) evaluated and treated. I also consent to allowing the authorized person(s) listed below to obtain treatment of my child.

Signature of guardian: _____

Others who can bring in your child for treatment and evaluation:

1: _____ Relationship: _____

2: _____ Relationship: _____

Emergency Contact (other than parents)

Name: _____ Relationship: _____ Phone: _____

Financial Responsibility/Release Information

I hereby give authorization to file claims and assign insurance payments directly to Platte County Pediatrics for services rendered. I understand I am financially responsible for charges not covered by my insurance. But not limited to medical services deemed routine, or not medically necessary by my insurance company. Co-pays, deductibles, co-insurance amounts or non-covered items are my responsibility as well as outstanding charges the insurance has not paid in a timely manner. I hereby authorize release of information acquired in the course of examination and treatment to my insurance company or other necessary medical person assisting in care. **I agree to pay any collection fees, attorney fees, or court cost assessed in the event my account is placed with an outside agency for collection.** This authorization is considered valid until revoked by me in writing.

X _____ Date: _____