PEDIATRIC ACKNOWLEDGMENT AND CONSENT

I understand that **Grants Pass Clinic, L.L.P.**, (referred to below as GPC) will use and disclose health information about me (or my child).

I understand that my (or my child's) health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my (or my child's) health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that GPC may **use and disclose** my health information in order to:

- Make decisions about and plan for my (or my child's) care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my (or my child's)care and treatment;
- Determine my (or my child's) eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my (or my child's) health care; and
- Perform various office, administrative and business functions that support my (or my child's) physician's efforts to provide me (or my child) with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how GPC will handle health information about me (or my child). This written description is known as a **Notice of Privacy Practices** and the OHA pamphlet **Minor Rights: Access and Consent to Health Care** which describe the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of GPC, and my (or my child's) rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version to GPC's Notice of Privacy Practices in effect will be posted in waiting/reception areas and available on the website at www.grantspassclinic.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that GPC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices and Minor Rights: Access and Consent to Health Care. I also understand that if I do not sign or return this Acknowledgment, I am not agreeing to the Privacy Practices and GPC can no longer provide service to me.

By: _____ **Patient Phone:**_____ Date: _____
(Patient Signature, 15-18 years old)

_____ Date of Birth _____ MRN number: _____
(Print patient's name)

-OR-

By: _____ **Patient Phone:**_____ Date:_____
(Patient representative, 0-14 years old)

Patient's Name: _____ Date of Birth _____

Description of Representative's Authority: _____

Grants Pass Clinic, L.L.P.

Financial Policies

Thank you for choosing Grants Pass Clinic for your healthcare needs. To ensure we can provide high-quality care, we ask that patients review and understand our financial policies. Working together helps ensure accurate billing and timely payment for services rendered.

If you have questions or need assistance, please contact our Business Office at **541-472-5580**.

Patients are required to read and sign this agreement prior to receiving treatment.

Payment Options

We accept **cash, check, Visa, MasterCard, and Discover**. A **$25.00 fee** will be charged for all returned checks.

Insurance

It is the patient's responsibility to verify insurance benefits directly with their insurance carrier. Please note that we are unable to submit claims to certain non-participating insurance plans.

We expect payment from insurance carriers within **90 days**. Any remaining balance after that time may be transferred to the patient's account and will be due in full.

Patients are responsible for providing accurate and current insurance information. If a claim is denied due to invalid information, failure to report insurance changes, or timely filing issues, the patient will be responsible for the full balance.

Self-Pay Patients

Self-pay patients include individuals without insurance or those whose insurance plans we do not participate with. A **minimum pre-payment of $150** is required prior to treatment.

Copayments and Non-Covered Services

Copayments are due at **check-in**. Any services not covered by insurance must be paid **at the time of service**.

Other Services

Some services and supplies are not available on a credit basis and may require partial or full payment in advance. If applicable, you will be provided with a separate payment policy.

Authorizations and Referrals for Out-of-Network Plans

If your out-of-network insurance plan requires a referral or prior authorization, it is the patient's responsibility to ensure the proper authorization has been obtained. Services provided without required authorization may be denied by insurance, making the patient responsible for all charges.

Payment Arrangements

Payment plans may be available with approval from the Billing Office. The minimum monthly payment is **10% of the total balance** or **$25.00**, whichever is greater. Monthly payments are required in addition to any copayments for future visits.

We partner with **Resolution Resource** to assist with payment plans. Accounts not kept in good standing may be sent to an external collection agency. If an account is placed in collections, Grants Pass Clinic reserves the right to dismiss the patient and any related family members from the practice.

Acknowledgment and Assignment of Benefits

I acknowledge full financial responsibility for services provided by Grants Pass Clinic. I confirm that I have read and understand these financial policies. I authorize my insurance benefits to be paid directly to Grants Pass Clinic, LLP. I understand that if my account goes into default, I am responsible for all collection costs, including court costs and reasonable attorney fees. I authorize Grants Pass Clinic and my insurance company to release any information necessary for the processing of my claims.

_____ _____

Patient's Name (please print) Date of Birth

_____

Name of Responsible Party (please print)

_____ _____

Signature of Responsible Party Date

Grants Pass Clinic, L.L.P.
495 SW Ramsey Ave. • Grants Pass, OR 97527 • (541) 476-6644

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION — Child 1

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 2

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 3

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 4

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

Who has legal custody of patient(s): ____ Parent____ Mother Only____ Father Only____ Foster Parent____ Grandparent
*If not biological/natural parents, court documents must be present at time of visit

PARENT- LEGAL GUARDIAN Last Name	First	Initial
Address _____ ✓ if same as patient		DOB

City	State	Zip	Home Phone	Driver's License
Employer	Work Phone	Occupation		

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RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY Last Name	First	Initial	Relationship to patient
Address _____ ✓ if same as patient			DOB
City	State	Zip	Home Phone	Driver's License
Employer	Work Phone	Occupation

PATIENT EMERGENCY CONTACT

Contact Name	Relationship
Emergency Contact Address	Phone	Alternate Phone
City	State	Zip

INSURANCE INFORMATION

Primary Insurance Carrier	Member ID	Group No.
Subscriber Name:	Subscriber DOB	Group Name:
Secondary Insurance Carrier	Member ID	Group No.
Subscriber Name	Subscriber DOB	Group Name

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT

_____ _____

Signature *Date*

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

Name:_____ **DOB:** _____ **MRN:**_____

Household

Please list all those living in the child's home.

Name	Relationship	Age

Are there siblings not listed? If, so please list their names, ages and where they live. _____

_____

What is your child's current living situation if not with both biological parents?

☐Lives with adoptive parents ☐Joint custody

☐Lives with foster parents ☐Single custody

If one or both parents do not live in the home, how often does the child see the parent (s) not in the home

_____

_____

Birth History

Prenatal Complications (i.e. Diabetes, hypertension)_____

_____

Born ☐Preterm Gestational Age_____

☐Full-term Birth weight_____

Type of Delivery?

☐Repeat Cesarean ☐Emergency Cesarean

☐Assisted Vaginal ☐Unassisted Vaginal

During pregnancy did the mother:

Smoke Tobacco ☐Y ☐N If so, Packs/day_____

Drink Alcohol ☐Y ☐N

Use Drugs ☐Y ☐N if so, type/when_____

Was initial feeding

☐ Breast milk How long:_____

☐ Formula Type:_____

Medications

List medications and dose your child is currently taking.

Include vitamins and herbal supplements.

Allergies/reaction:

Preferred Pharmacy?

Surgery/Hospitalization

Hospitalization: ☐Y ☐N If so, when and why:_____

_____

Surgeries: ☐Y ☐N If so, when and why:_____

_____

Medical History Does your child have or has your child ever had:

Please check if your child has any of the following:

☐Asthma ☐Frequent ear infections ☐Depression ☐Anxiety ☐ADHD ☐Sleeping problems ☐Seizures

☐Nasal Allergies ☐Urinating Problems ☐Constipation ☐Heart burn ☐Ulcers ☐Heart problems ☐Cancer

☐Migraines ☐High Cholesterol ☐Eating concern ☐Poor vision ☐Skin Problems ☐Thyroid disease ☐Anemia

☐Other Please Specify:_____

For Girls: ☐ Y ☐ N Has had her first period? If so, what age?_____

☐ Y ☐ N Any problems with your period? If so, what type? _____

Social History

Is there:

☐ Y ☐ N Tobacco use in the home?

☐ Y ☐ N Alcohol use in the home?

☐ Y ☐ N Recreational Drug use in the home?

☐ Y ☐ N Firearms in the home?

☐ Y ☐ N A smoke detector in your home?

☐ Y ☐ N A carbon Monoxide detector in your home

☐ Y ☐ N Pets in your home, Type_____

Does you child:

☐ Y ☐ N Use the proper car seats/seatbelts?

☐ Y ☐ N Wears a helmet when biking?

☐ Y ☐ N Exercise_____ (times/week

☐ Y ☐ N Attend daycare/school? If yes, where:

_____

☐ Y ☐ N Participate in after school activities? If yes, what type:

_____

CONTINUE ON BACK SIDE

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

Family Medical History

	Child's Father	Childs mother	Brother	Sister
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer before the age 55, type_____	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness/depression	☐	☐	☐	☐

Immunization History

☐ Y ☐ N My child is up to date on immunizations
☐ Y ☐ N My child is partially immunized but not up to date.
☐ Y ☐ N My child has not started immunizations but I intend to fully immunize my child
☐ Y ☐ N My child has not started immunizations and I will only be doing certain immunizations
☐ Y ☐ N My child has not started immunizations and never will

*******PLEASE PROVIDE THE CLINIC WITH A CURRENT COPY OF YOUR CHILDS IMMUNUZATIONS*******

Communication Needs

What is Primary Language your child speaks _____ What is Primary language of Parents_____

☐ Y ☐ N Does your child or yourself require any special communication needs? If yes, explain _____

_____

Patient Education Preferences

Would you prefer patient education be provided to you or your child by:

☐Demonstration ☐Written Materials ☐Other, explain_____

Grants Pass Clinic, L.L.P.

Pediatrics Department

495 SW Ramsey Avenue

Grants Pass, OR 97527

Grants Pass Clinic, LLP
495 SW Ramsey Avenue
Grants Pass, OR 97527
541-472-5560

PARENTAL CONSENT FORM

I give permission for_____
Representative's Name

OR_____ OR _____
Representative's Name *Representative's Name*

to take my child:_____ _____
Child's Name *Child's Date of Birth*

to _____or the covering provider at Grants Pass Clinic, LLP.
(Provider Name)

I also give permission for the provider to examine and treat my child. I designate that the above named representative(s) may receive protected health information regarding my child and their visit to the provider.

My child has the following drug allergies:_____

_____

_____ _____
Signature of Parent or Guardian *Date*

Right to Revoke: If you decide you do not want the person(s) named above to continue to act on behalf of your child you have the right to revoke this permission. Any revocation can only apply on or after the date that we receive your Revocation.

REVOCATION:

I no longer want the person(s) named above to act on behalf of my child. All permissions listed above are no longer applicable.

Signature_____Date_____