South Sound PEDIATRICS

# SOUTH SOUND PEDIATRICS INFORMATION UPDATE FORM (18 YEARS +)

PATIENT NAME: _____ DOB: ____/____/_____

ADDRESS: _____PHONE: _____

CITY: _____ STATE: _____ZIP: _____

EMPLOYER: _____EMPLOYER PHONE #: _____

MOTHER: _____PHONE #: _____

STEPMOTHER, IF APPLICABLE: _____ PHONE #: _____

FATHER: _____PHONE #: _____

STEPFATHER, IF APPLICABLE: _____PHONE #: _____

**EMERGENCY CONTACT**

NAME: _____RELATIONSHIP: _____PHONE #_____

**AUTHORIZATIONS**

Name: _____ Relationship: _____ Phone #: _____

☐ All medical records (Billing & Appointment Info) ☐ Billing Information Only ☐ Appointment Information Only

Name: _____ Relationship: _____ Phone #: _____

☐ All medical records (Billing & Appointment Info) ☐ Billing Information Only ☐ Appointment Information Only

Name: _____ Relationship: _____ Phone #: _____

☐ All medical records (Billing & Appointment Info) ☐ Billing Information Only ☐ Appointment Information Only

**South Sound Pediatrics has my advance consent to speak with parent(s) listed regarding my medical care (Excluding conditions relating to the patients' reproductive care including but not limited to, contraception, pregnancy and pregnancy terminations, sexually transmitted diseases, alcohol and/or drug use and mental health).**

Patient Signature: _____ Date: _____

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**INSURANCE AND SUBSCRIBER INFORMATION**

NAME: _____DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____

EMPLOYER: _____ EMPLOYER PHONE #_____

INSURANCE COMPANY: _____

MEMBER ID: _____ Group Number: _____

***Insurance card and driver's license/ID is required at every visit. Please provide Insurance card and legal identification when submitting this form.**

**Please sign below in acknowledgement of the following statements:**

- I understand I may revoke this authorization by a written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- **Special Disclosure:** All records pertaining to psychiatric/mental health, chemical dependency, STD and/or AIDS/HIV related illness/testing will **not be** verbally released unless otherwise indicated by initialing here: _____
- I understand that once information is verbally released pursuant to this authorization, these facilities cannot prevent the redisclosure of the information to another third party.
- These facilities will not condition treatment on my signing this authorization.
- I understand that this authorization will be in effect until I revoke this authorization by written request at any time to the address listed above.
- I understand this authorization **must be filled out completely**, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.

_____ _____ _____

Print Name Signature Date

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## Financial Responsibility, Release of Information, and Assignments of Benefits:

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance company.

## Notice of Policy Regarding Disruptive Behavior:

South Sound Pediatrics is a family and patient centered healthcare clinic. We are committed to providing a safe and welcoming environment for all. Aggressive, threatening, intimidating or disruptive behavior will not be tolerated.

- Examples of aggressive, intimidating or disruptive behavior include but are not limited to:
- Verbal harassment – yelling, threatening or intimidating words or body language
- Demanding, controlling or manipulative statements and requests
- Abusive/offensive language or swearing
- Physical violence or aggression
- Threats of any kind

**South Sound Pediatrics will not tolerate ANY form of aggressive or disruptive behavior. These types of behaviors will result in dismissal from the practice**.

## Notice of Privacy Practices:

South Sound Pediatrics has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns or complaints. We may change the Notice of Privacy Practices at any time, and you may contact our office manager at (360) 456- 1600 ext. 104 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

## Notice of No-Show Policy:

South Sound Pediatrics has a responsibility to inform you of our no-show policy and the consequences of no-show appointments. While we realize that there may be a good reason for you to miss an appointment, we also hope you realize a specific time was set aside for your visit. Each time you miss an appointment you deprive another patient of the opportunity to see one of our providers.

If you are unable to keep your scheduled appointment, we would appreciate a 24-hour notice of cancellation so we may utilize this time for another patient. Established families are limited to 3 missed appointments within 365 days. New patients who missed an appointment, cancel at the last minute, or arrive late more than once will not be accepted as a new patient. Please call to reschedule your appointment. Our office opens at 8 a.m. Monday through Saturday. South Sound Pediatrics and/or our answering service are always available to take your calls.

**By my signature below I acknowledge receipt of the policies above given to me by South Sound Pediatrics.**

_____

Printed Name Signature Date