Welcome to KidsFirst Pediatrics, Prof. LLP

Please fill out completely

We use this information to bill your insurance for your child's visit to our clinic. Insurance companies have strict rules regarding billing policies and how quickly a bill must be submitted after an office visit. If any of the information is incomplete or inaccurate, your claim may be denied by your insurance company, leading you to be billed for today's visit. If you have questions, please ask for assistance from our front office staff or billing department staff.
PLEASE PROVIDE AN EMAIL ADDRESS SO WE CAN INVITE YOU TO OUR PATIENT PORTAL.

Patient Information: (This Section refers to **PATIENT ONLY**)

1st Patient Full Name: _____DOB: _____
Race: _____ Ethnicity:_____
Preferred Language: _____
2nd Patient Full Name: _____ DOB: _____
Race: _____ Ethnicity:_____
Preferred Language: _____
3rd Patient Full Name: _____ DOB: _____
Race: _____ Ethnicity:_____
Preferred Language: _____
4th Patient Full Name: _____ DOB:_____
Race: _____ Ethnicity:_____
Preferred Language: _____

Address:_____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Email: _____

Responsible Party: (Person who should receive the bill and/or **legal** guardian.)
Name: _____ DOB:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Social Security #: _____ Relationship to Patient: _____
Primary Phone: _____ Secondary Phone:_____
Email Address: _____ Referred By:_____

Preferred Means of Contact (Check One): Primary Phone Secondary Phone Email

Insurance Information: {Please complete Thoroughly. We will need a copy of your insurance card}. If thesame as the responsible party, please check here; if not, please fill out this section below.

Primary Insurance: _____ Primary Insured: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Phone #: _____ Phone# _____
ID#/Policy: _____ Social Security#: _____
Group#: _____ Insured Date of Birth: _____
Employer: _____ Relationship to Patient: _____

Notify in Case of Emergency (Not living with you)
Name: _____ Phone#: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Relationship to Patient: _____

To the best of my knowledge, the above information is complete and accurate. In signing this form I understand that I give all information needed for KidFirst Pediatrics to bill my insurance company. If the information is incorrect or inaccurate, I will be responsible for billing my own insurance.

Signature: _____ Date: _____

AUTHORIZATION FOR CHILD'S TREATMENT

I am the Parent/Guardian of:_____**DOB:**_____

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I am the Parent/Guardian of: _____**DOB:** _____

I am the Parent/Guardian of:_____ **DOB:**_____

I am the Parent/Guardian of:_____**DOB:** _____

I hereby give KidsFirst Pediatrics specific authorization to treat my child, including authorization to administer immunizations.

I further authorize the practice to triage or discuss with the designated caregivers listed below either in person or by phone. My child's symptoms and/or medical condition may be released to assist and advise the caregiver concerning the immediate treatment options for my symptomatic child on a need-to-know basis.

Please indicate the name and relationship to the patient that you are giving authorization.

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Parent/Guardian signature **Date**

_____ _____

Print name: _____

KidsFirst Pediatrics, Prof. LLP

RECEIPT OF NOTICE OF PRIVACY PREACTICES

WRITTEN ACKNOWLEDGEMENT FORM.

I, _____ , have read a copy of KidsFirst Pediatrics, Prof. LLP's
Print Parent of Guardian's Name
Notice of Privacy Practices.

Names of Children:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Parent **Date**

Parent Name: _____

Date: _____

Dear Patient:

This note is to explain the standard billing policy we follow during physical or “well child” visits. After your visit for a physical/ well child visit, you/your insurance company will be billed for this specific service using a preventive medicine billing code. If during this same visit, time allows for a specific problem to be addressed beyond the well care visit, you/your insurance company will be billed for this additional service as well with a problem-oriented billing code. Thus, one visit my generate two billing codes, preventive and problem oriented.

KidsFirst also offers telehealth appointments that are billed to you/your insurance.

All billing we do follows the professional standard guidelines for KidsFirst Pediatrics and these guidelines are contractually agreed to with all insurance companies

Sincerely,

KidsFirst Pediatrics

I have received and read the preceding Information:

_____ _____

Patient Printed Name Patient Signature and Date

Parent/Guardian Financial Policy

The physicians of KidsFirst Pediatrics appreciate the challenges in understanding insurance coverage. Our office provides medical services in good faith with the exceptions that they will be paid for those services. All our services are billed under KidsFirst Pediatrics name and tax identification number (TIN).

Your Medical Insurance:

Your medical insurance policy is a contract between you and your employer and/or you and the insurance carrier. Kid's First Pediatrics is not a party to that contract. Your coverage, the requirements for co-payments, deductibles and co-insurance are all defined in your policy. You are responsible for reading, understanding, and following the procedures outlined in your insurance policy handbook. We will be happy to assist you when and where we can with specific questions and concerns. **Your insurance plan or federal government determines the range of benefits available to you.**

Who is Responsible:

You are responsible for all charges, whether they are incurred in the hospital or office. We are happy to assist you by processing all claims for our services with your primary insurance, as well your secondary insurance if applicable. Once your insurance pays their portion, any remaining portion of the bill will be transferred to patient responsibility. **Providing accurate, up to date insurance information to KidsFirst Pediatrics is the patient's responsibility**. This should include all insurance policies by which the patient is currently covered, as well as which insurance is considered primary vs. secondary when applicable. **Inaccurate information will result in insurance claim denial and make it difficult or impossible for immediate payment for the services that were provided to you.**

Copays, Deductibles, and Coinsurance:

Kid's First Pediatrics contracts with insurance plans and our fees are based on the term of our agreement with these entities. The patient will often have financial responsibility for that portion of these fees.

Copays must be paid at the time of the office visit, for each child seen. We cannot waive any copays, deductibles or coinsurance amounts defined as the patient responsibility under the term of our contract with your insurance plan. In fact, such a waiver may violate state and federal laws. If a co-pay cannot be paid at the time of services, then a $15.00 charge will be added to the account. A $25.oo charge will be rendered for all returning checks.

Use of Collection Agencies:

Default on a patient balance or on a payment plan arrangement past 120 days may cause your account to be immediately turned over to a collection's agency. Once a patients account has been turned over to a collections agency, the patient may be discharged from the practice and cannot schedule further appointments with practice until payment(s) have been received in full. Any family declaring bankruptcy against KidsFirst Pediatrics will be dismissed form the practice and will need to find care at another facility. **Patients are responsible for all legal fees associated with collections.**

If you have any question about your account or balance or would like to discuss a payment plan arrangement, please contact our patient's billing representative at 303-239-8327, extension #105.

By signing the office policy, you are agreeing and authorizing the release of medical and/or financial information needed to determine claims and benefits. This information can be released to related healthcare services and agents, including your insurance carriers.

Signature: _____ Date: _____

Parent/Guardian Office Policy

Parent/Guardian Compliance:

KidsFirst Pediatrics requires all forms to be updated, by parent /guardian, once a year to comply with best practices. This ensures that we have the correct insurance and information on file for your child/children. All forms are to be filled out in their entirety.

Our Practice ***will not*** become involved in any legal agreements between divorced or separated parents unless we are legally required to do so. The parent or guardian who brings the child/children in will be responsible for the account and cost associated with visit.

Appointments:

Patients are seen by appointment only. However, we will try and accommodate patients without appointments, but there could be a longer wait time. Patients that have appointments will have priority over time slots. Please call ahead for any appointments needed.

A parent/guardian must accompany any child to their appointments. It is required that a parent/guardian be present for routine Well Care Visits, or you may be asked to reschedule. For acute visits, written permission must be provided on our Minor Child Appointment Consent form to allow family members to bring your child in for scheduled appointments.

As a courtesy, KidsFirst Pediatrics does send out numerous appointment reminders, including one the day prior to your child's scheduled appointment. It is ultimately the parent/guardian's sole responsibility to remember all appointment times.

Each patient has his/her own appointment. If a sibling needs medical attention, please alert the front staff members in advance. Any added sibling may result in longer wait times.

Patients arriving 15 minutes or later after their scheduled appointment may be asked to reschedule for a later time or day.

Failure to show at your scheduled appointment or failure to call 24 hours in advance may be subject to a charge. Your insurance will not cover this cost. If you have multiple missing appointments within a 12 month period as an individual patient or as a family, you may be asked to transfer care to another practice.

Medication Refills:

Medication refills can take up to 48 hours' notice to refill and must be called in by parent or guardian. Please make sure you are planning accordingly. If you need a medication refill and have not been seen as requested, a one-time refill may be given, depending on the circumstance, and an appointment is required at the time of refill.

Form Release/Medical Records:

Please allow up to 2-7 business days on all form requests and 30 days for medical records. A HIPAA compliant release form is required and must be completed for records to be transferred. A patient's medical record can be transferred from physician to physician at no cost. Any other request will be subject to a record transfer fee under Colorado Statute. The fee starts at $14.00 and can increase from there depending on the size of the record and the information provided. There is $50.00 charge for all legal forms, including FMLA forms.

Signature: _____ Date: _____