

Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Phone: (512) 392-1700 Fax: (512) 396-8743

Patient Information

Patient's Name: _____ **DOB:** _____

Gender: Male Female

Race: African-American White/Hispanic Asian Other: _____

Preferred Contact Number: (____) _____

Address: _____
Street City State Zip Code

Name(s) of other children that are seen here and Date of Birth

Parent(s) or Guardian(s) Information

Mother/Guardian Name: _____ **Birth Date:** _____

Relationship to Patient: _____

Primary Phone: (____) _____ **Secondary Phone:** (____) _____

Address if different from above:

Employer: _____ **Wk#:** _____ **Social Security #** _____

Father/Guardian Name: _____ **Birth Date:** _____

Relationship to Patient: _____

Primary Phone: (____) _____ **Secondary Phone:** (____) _____

Address if different from above:

Employer: _____ **Wk#:** _____ **Social Security #** _____

The person(s) listed below have my permission to seek medical attention for my child at Corridor Primary Care Pediatrics.

Name	Relationship to Child	Phone Number:
Name	Relationship to child	Phone Number:
Name	Relationship to child	Phone Number:

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.

Date: _____ **Signature** _____

Print Name _____ **Referred to our office by:** _____



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www.corridorpd.com

Nurse Practitioner Consent

Date: _____

Patient: _____

Patient DOB: _____

I understand that Corridor Primary Care has Pediatric Nurse Practitioners on staff.

Pediatric Nurse practitioners are registered nurses with advanced academic and clinical education in pediatric health care, pharmacology, child development and family dynamics.

PNPs provide the following care:

- Physical exams
- Diagnose and treat common acute illnesses
- Provide management and counseling
- Serve as advocates

I understand that I may be offered appointments for sick or well care with a nurse practitioner. I understand that it is my responsibility to know if my appointment is with a physician or a nurse practitioner. I agree to have my child(ren) treated by a nurse practitioner if I schedule an appointment with one.

Parent or guardian

Date

Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient

DOB



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Insurance Information

Patient: _____ Sex: _____ DOB: _____

Primary Insurance Information:

Insurance Company: _____ ID # _____

Group # _____ Effective Date: _____

Employer: _____ Work Phone: _____

Policyholder: _____ Sex: _____ DOB: _____

Policyholder Social Security #: _____

Policyholder Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Secondary Insurance Information:

Insurance Company: _____ ID # _____

Group # _____ Effective Date: _____

Employer: _____ Work Phone: _____

Policyholder: _____ Sex: _____ DOB: _____

Policyholder Social Security #: _____

Policyholder Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Date _____ Signature _____

Authorization for Medical Treatment of Minors

I authorize Corridor Primary Care Pediatrics to provide medical care to my teenage child (15 years to 18 years) without an accompanying adult. If immunizations are to be given, I agree to be available by phone for a verbal consent

Parent/Legal Guardian Relationship Date

Parent/Legal Guardian Relationship Date

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Financial Policy

I understand, accept, and acknowledge the following terms: (please initial each line)

- _____ Payment for all services is my responsibility and is due and payable at the time services are rendered.
- _____ If my health insurance carrier has accepted Corridor Primary Care (CPC) as a participating provider at the time of service, CPC will submit a claim to my insurance carrier.
- _____ Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.
- _____ If my health insurance carrier HAS NOT accepted CPC as a participating provider at the time of service, I am responsible for full payment at the time of service unless prior arrangements have been made with CPC's billing department.
- _____ Upon my request to CPC's billing department, documentation will be provided so that I may submit a claim for reimbursement of out-of-pocket expenses from my insurance carrier.
- _____ Any contract for insurance coverage is made between my employer, the insurance company and myself. CPC has no influence over available benefits or the approval of claims.
- _____ If I wish to use my insurance benefits to cover the cost of any ordered tests, procedures or visits to third party providers it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers and specialists. Payment for such services is my responsibility under the terms provided by said individuals.
- _____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible, these requests should be made 5 days prior to the appointment date with the specialist. It is up to the discretion of a CPC provider whether or not to issue a referral requested after the appointment or procedure date.
- _____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to my insurance carrier.
- _____ I am responsible for all co-payments and non-covered services at the time of service unless prior arrangements have been made with CPC's billing department.
- _____ Any co-insurance, deductibles or rejected claims are to be paid in full to CPC within 30 days of receipt of a bill.
- _____ Any checks returned unpaid by your financial institution will be subject to a fee of \$25.00.
- _____ You understand if your account is submitted to a collection agency, the fact that you received treatment at our office may become a matter of public record.
- _____ In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- _____ Overpayments on accounts will be refunded at your request. If no such request is made, the overage will be applied as a credit to your account. If there is a patient due balance elsewhere on the account, the credit will be applied to the balance. You may use this credit for any services provided by our office.

Records Release: I hereby authorize the release of information, including medical and billing information, to my referring doctor, insurance company, the responsible party named above, and the immediate family. Assignment of Benefits: I hereby authorize payment of medical benefits to Corridor Primary Care for services rendered to myself and/or dependents.

Patient Name: _____ Date of Birth: _____

Date: _____ Signature: _____

Print Name: _____