WELCOME TO KIDS WAY CLINIC

This is FRONT & BACK. Please don't leave any blanks.
If it does not apply to you, please put "N/A"
PLEASE RETURN WITH YOUR PHOTO ID AND INSURANCE CARD.

Today's Date: _____ Drug Allergies: _____ Whos Filling Out Form: _____

Patient Personal Demographics

Patients Full Name: _____
Last First M.I. DOB.

Patients Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Email: (For portal account): _____

Who does our patient live with? ***CIRCLE ONE PLEASE*** : Mom **OR** Dad **OR** Both **OR** Other explain: _____

Who will receive text message notifications for future appointment reminders? (please check ONE box) Mother ☐ or Father ☐

Who will receive email notifications for appointment reminders? (please check ONE box) Mother ☐ or Father ☐

Any home/school dynamic information that our office may need to know about the patient(s):

_____

_____

School/Daycare: _____
Name of School Grade

Patient's Primary Insurance Information

Primary Insurance _____
Name of Insurance Group Name Group # ID #

*If Private Insurance _____
Policy Holder Full Name DOB SSN #

Patient's Secondary Insurance Information

Secondary Insurance _____
Name of Insurance Group Name Group # ID #

*If Private Insurance _____
Policy Holder Full Name DOB SSN #

Mothers Demographics (OR legal guardian)

Mothers Full Name: _____
Last First M.I. DOB.

Employer and Phone number: _____

Mothers Address:
(if different than patient) _____
Street Address Phone number

_____
City State ZIP Code

Fathers Demographics (OR legal guardian)

Fathers Full Name: _____
Last First M.I. DOB.

Employer and Phone number: _____

Fathers Address:
(if different than patient) _____
Street Address Phone number

_____
City State ZIP Code

Sibling Demographics (If We Are Provider, Patient is 18 & Under)

Sibling: _____
Last *First* *DOB*

Sibling: _____
Last *First* *DOB*

Sibling: _____
Last *First* *DOB*

Emergency Contact for Patient Besides Parent or Guardian

Name _____
Full Name *Phone #* *Relationship to Patient*

Any Person that is NOT Allowed to Bring/Change Info

Name _____
Full Name *Phone #* *Relationship to Patient*

Step-Parent Demographics (If Any)

Step-Mother: _____
Last *First* *M.I* *DOB* *Cell #*

Step-Father: _____
Last *First* *M.I.* *DOB* *Cell #*

Does patient live with step-parent full time or part time? (please check box) Yes ☐ or No ☐ Explain:_____

Consents

I authorize the following people bring and to receive medical/ financial information about my child/ren:

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

- **FINANCIAL POLICY & CONSENTS**
- **PLEASE INITIAL**

X_____I have read, understand, and agree to Kids Way Clinic financial policy. I understand that charges *not* covered by my insurance company, as well as applicable copayments and coinsurance, and deductibles and any other outstanding charges older than 30 days from the date of service, are solely my responsibility, and will be billed accordingly. If the wrong insurance is given, or if both primary and secondary insurances are not given at the time of service, I waive my right and the financial responsibility will become mine.

X_____I have read, understand, and agree My Primary Care Provider/Physician will be changed to Dr. Sreekar Maruvada of KIDS WAY CLINIC, PRIOR TO TREATMENT as required by the office and the insurance policy.

X_____I have read, understand, and agree to authorize KIDS WAY CLINIC to release pertinent information on my behalf to my insurance company when requested, or to facilitate the payment of a claim. I authorize my insurance benefits be paid directly to KIDS WAY CLINIC, Sreekar Maruvada, MD

X_____I have read, understand, and agree to consent to KIDS WAY CLINIC to importing their medication history as provided by SureScripts.

X_____I have read, understand, and agree to consent to HIPAA contains a health information exchange exception allowing the electronic exchange clinical data and patient health information through a networked environment, depending on the purpose of the exchange. However, in some instances, an individual has the right to grant or deny sharing data with a health information exchange.

X_____I have read, understand, and agree to consent to HIPAA contains a public health exception that allows providers to share patient data with a public health agency when the information is needed for public health purposes, even if the patient does not consent. However, in some states patients can opt out of sharing data with a public health agency. If you opt out, please provide that in writing.

X_____We participate in MOST insurance plans, which can be verified by calling the phone number on the back of your insurance cards. If you are insured by a plan we do not have a contract with, or are not able to provide us with an up to date insurance card, payment is expected at each visit. Knowing your insurance benefits is YOUR RESPONSIBILITY. Please contact your insurance company with any questions you may have regarding coverage. If the correct insurance is not provided and the claims are not paid, YOU are responsible for payment and will receive a statement from our office.

X_____ALL COPAY & DEDUCTIBLES must be paid prior to service. This arrangement is part of your contract with the insurance company, failure to do so results in possible fraud on both parties.

X_____I acknowledge the offices Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

KIDS WAY CLINIC has permission to treat the patient for any medical problems. Procedures may be performed once made aware. I authorize the release of my medical information to any physician/facility that I may be referred to.

I have read and understand all of the above policies.

PARENT PRINT: _____DATE: _____
PARENT SIGNATURE: _____
PREFERRRED PHARMACY:_____