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Patient Information

First Name: _____ Last Name: _____

Middle Initial: _____ Date of Birth: _____ Sex: Male Female

Parent/Guardian Information

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____ Sex: Male Female

Relationship: Mother Father Step-Mother Step-Father Foster Parent Other _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Consent for text message communication: Yes No
Consent to leave messages on voicemail: Yes No

Parent/Guardian Information

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____ Sex: Male Female

Relationship: Mother Father Step-Mother Step-Father Foster Parent Other _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Consent for text message communication: Yes No
Consent to leave messages on voicemail: Yes No

Parents are: Married Divorced Separated Living Together Other: _____

PLEASE COMPLETE BOTH SIDES OF PAPERWORK

21321 E. Ocotillo Road, Suite 110, Queen Creek, AZ 85142
Tel: (480) 677-4545, Fax: (480) 677-4356, Web: www.jjpediatrics.com

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitles, private insurance, and any other health plan payment to JJ Pediatrics PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including, but not limited to co-payment and annual deductibles. I hereby authorize said assignee to release all information to secure the payment. I hereby acknowledge that I have seen a copy of JJ Pediatrics PLLC's Notice of Privacy Practices. I understand I may request and receive a copy of the notice at any time.

Signature: _____ Date: _____

Authorization and Assignment

All co-payments are due at time of service, I authorize JJ Pediatrics to release medical information for claim reimbursement from insurance companies to whom we have submitted a claim. I also assign the claim payment to be made to JJ Pediatrics. In the event my insurance is delayed or the claim is denied it will be my responsibility to make payment in full immediately.

Signature: _____ Date: _____

Privacy Practices Acknowledgement

I have been provided an opportunity to review The Notice of Privacy Practices and agree to all Terms.

Signature: _____ Date: _____

Insurance Policy

As a courtesy, we will do our very best to verify insurance is active at the time of service BUT it is not a guarantee of benefits and YOUR insurance can retract verification and payment at any time. It is YOUR responsibility to verify that JJ Pediatrics AND the providers at JJ Pediatrics are in network contracted providers with your plan. Any claims not made by your insurance in a timely manner is your responsibility. This includes previous, current, and future claims.

Signature: _____ Date: _____

Prescriptions Policy

I give permission to the provider(s) at JJ Pediatrics to write, call-in, and electronically submit prescriptions for the patient.

Signature: _____ Date: _____

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Late Arrival Policy

New patients are to arrive 15 minutes before their scheduled appointment time to complete new patient paperwork.
Established patients are to arrive 5-10 minutes before their scheduled appointment time. This allows enough time confirm and updated patient information before the actual appointment time.
All Patients a grace period of 10 minutes will be permitted for unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 10 minutes late for their appointment, the appointment will be marked as no show and the patient will need to be re-scheduled. It will be up to the providers discretion whether the appointment can still be accommodated same day. If a patient arrives 10 minutes late and patient information still needs to be updated upon check in, it will be providers discretion whether the appointment can still be accommodated.
This process will ensure patients that do arrive on time are seen in a timely manner.

No Show Policy

In order to better serve our patients, we want to give you a friendly reminder of our No show/cancellation policy.
For any appointments, we do require 1 hour notice for any cancellation or re-scheduling. Any visit not cancelled or re-scheduled with 1 hour notice will be considered a No show.
After 2 or more No shows our office manager will reach out and there could be a possible dismissal from our office. Please be advised we are sending out text reminders a day prior to confirm your appointment, please reply YES to confirm or NO to cancel.
This policy is in place to be able to help reduce any unused appointment slots and therefore create availability for other patients. Thank you for your understanding.

_____ _____

Signature **Date**

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