_____Village Pointe Pediatrics, P.C. /_____ Dundee Pediatrics

Front Desk:

Primary E-mail address:

Only ONE email address: this will be used for appointment reminders, statements and patient portal.

Child(ren)'s Information

ONLY list names of children living in your home full time who are under the age of 19 years.

Name MI Last	DOB	M/F	Name MI Last	DOB	M/F
1.			4.		
2.			5.		
3.			6.		

Address: **City:** **State:** **Zip:**

Primary Provider

___K. Anderson ___J. Andresen ___Belin ___Byrne ___Christner ___Coffey ___Cohen ___Davey ___Dek ___Larson ___Steinauer ___Megan APRN ___Moe P.A.

Parent: ____MOTHER ____FATHER or ____Guardian	Parent: ____FATHER ____MOTHER or ____Guardian
Last: First: MI:	Last: First: MI:
DOB: / / SSN: / /	DOB: / / SSN: / /
Cell Phone: ( ) Land Line: ( )	Cell Phone: ( ) Land Line: ( )
Employer: Work Phone: ( )	Employer: Work Phone: ( )
___check if home address same as above, if not fill in below Address: City: State: Zip:	___check if home address same as above, if not fill in below Address: City: State: Zip:

Emergency contact outside your home: Name:_____ Phone: _____ Relationship:___

Person responsible for medical bills if NOT at same home address: ____Father OR ____Mother

Medicaid or Self Pay Information

_____ Yes, I am covered by NE Medicaid
_____ I am pending Medicaid
_____ I am not covered by insurance at this time

Insurance Information

Primary Insurance Name:_____
Policy Holder: ____Father _____Mother ____Guardian
Secondary Insurance Name:_____
Policy Holder: ____Father _____Mother ____Guardian

Financial Responsibility: I am aware that I am responsible for any outstanding balance whether or not paid by my insurance. I authorize payment of insurance benefits directly to Village Pointe Pediatrics, P.C. or Dundee Pediatrics. I understand that it is my responsibility to know my insurance benefits and coverage.

HIPAA: I acknowledge receipt of Notice of Privacy Practices as set forth by the Health Information Portability and Accountability Act (HIPAA) at this visit and at any future visits. I authorize Village Pointe Pediatrics or Dundee Pediatrics to release any of my or my dependent's medical or personal information for evaluation, treatment, consulting, and processing of insurance benefits.

Authorization to Mail, Call or E-mail: I authorize Village Pointe Pediatrics or Dundee Pediatrics representative to leave messages on my voicemail, answering machine and e-mail with communication, including but not limited to appointment reminders, referral arrangements, and balance notices.

Prescription History: I authorize Village Pointe Pediatrics to view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Consent to Treat: I, the parent/authorized guardian, give Village Pointe Pediatrics or Dundee Pediatrics consent to administer care/treatment for my child(ren) from the pediatricians and other health care providers employed by Village Pointe Pediatric, P.C. or Dundee Pediatrics.

Financial Policy: Is available on our website www.villagepointepediatrics.com

Immunizations: Our clinic requires families to vaccinate their children against preventable diseases. We use the Nebraska DHHS requirements for daycare and school participation and expect parents to keep their children up to date by the next subsequent well visit. This policy helps protect your child, as well as other patients in our clinic.

Parent/Guardian Signature: _____ **Date:** _____

My signature certifies that I have read, understand, and accept the terms of the above.