Village Pointe Pediatrics, P.C.
18018 Burke Street
Elkhorn, NE 68022
Phone (402) 573-7337
Fax (402) 614-2314

Dundee Pediatrics
5018 Underwood Ave., Ste 200
Omaha, NE 68132
Phone (402) 991-5678
Fax (402) 991-5358

village pointe | dundee pediatrics

NEW PATIENT REGISTRATION & CONTACT AUTHORIZATION

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Male: _____ Female: _____ Preferred Name (if different than above): _____

Street Address: _____

City: _____State: _____ Zip: _____ Primary Phone #: _____

PLEASE SELECT YOUR PRIMARY CARE PROVIDER				
☐ Dr. K. Anderson	☐ Dr. J. Andresen	☐ Dr. Byrne	☐ Dr. Christner	☐ Dr. Coffey
☐ Dr. Cohen	☐ Dr. J. Davey	☐ Dr. K. Davey	☐ Dr. Dek	☐ Dr. Larson
☐ Dr. Steinauer	☐ Dr. Wolfe	☐ Megan Kalil APRN	☐ Moe Garvin PA-C	

PARENT/GUARDIAN INFORMATION		PARENT/GUARDIAN INFORMATION	
Name		Name	
Relationship to Patient		Relationship to Patient	
DOB		DOB	
SSN		SSN	
Cell Phone		Cell Phone	
Work Phone		Work Phone	
Employer		Employer	
	COMPLETE IF DIFFERENT THAN PATIENT		**COMPLETE IF DIFFERENT THAN PATIENT**
Address		Address	
City/State/Zip		City/State/Zip	

CONTACT AUTHORIZATION

PRIMARY EMAIL (Please list only ONE email to be used for appointment reminders, statements and patient portal)

EMERGENCY CONTACT AND ADDITIONAL CONTACTS AUTHORIZED TO DISCUSS MEDICAL CARE		
NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

_____ _____
Signature of Parent, Guardian, or Legal Authorized Representative — Relationship to Patient

_____ _____
Printed Name — Date

STAFF ONLY	

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CONSENT TO TREATMENT & NOTICE OF PRIVACY PRACTICES

Please list all children under 19 years of age in the household:

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____

CONSENT OF TREATMENT

I, the parent or legal guardian, hereby give consent for Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics, and their physicians, nurses, and authorized healthcare staff to provide medical care for my child(ren). This includes routine examinations, preventive care, diagnostic testing, and treatment as deemed medically necessary. I understand that I have the right to ask questions regarding my child's care at any time.

FINANCIAL RESPONSIBILITY & INSURANCE

I understand that I am financially responsible for all charges incurred for services provided to my child(ren), regardless of insurance coverage or payment determination. I acknowledge that it is my responsibility to understand my insurance benefits, coverage limitations, referrals, and network requirements. I authorize payment of insurance benefits directly to Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics, as applicable. I understand that any remaining balance not covered by insurance is my responsibility and is due in accordance with office policy. I acknowledge that the full Financial Policy is available upon request at the office.

HIPPA PRIVACY ACKNOWLEDGMENT

I acknowledge that a copy of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA) is available upon request. I authorize Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to use and disclose my child's medical information as necessary for treatment, care coordination, consulting services, and insurance billing.

COMMUNICATION AUTHORIZATION

I authorize Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to contact me using phone, voicemail, text message, and/or email for purposes including, but not limited to, appointment reminders, test results, referral coordination, and billing or account notifications. I understand that messages may contain personal health information as appropriate for care and coordination.

PRESCRIPTION HISTORY REVIEW

I authorize my child's providers at Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to access external prescription history through Surescripts or similar electronic prescription monitoring services. I understand this may include prescriptions from other healthcare providers, pharmacies, and insurance data spanning several years.

IMMUNIZATION POLICY

Our clinic requires families to vaccinate their children against preventable diseases in accordance with recommendations from the American Academy of Pediatrics (AAP). We follow 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.

APPOINTMENT POLICY

To ensure timely care for all patients, we ask that families arrive on time for scheduled appointments. Arrivals more than 15 minutes late may require rescheduling at the discretion of the clinic, to avoid delays for other scheduled patients.

By signing below, I acknowledge that I have read, understand, and agree to the policies outlined above.

_____ _____
Signature of Parent, Guardian, or Legal Authorized Representative | Relationship to Patient

_____ _____
Printed Name | Date

STAFF ONLY	