Avera Medical Group Pediatrics Mitchell

ACCOUNT FORM

FOR OFFICE USE ONLY
Patient # _____
Guarantor # _____

Date _____

First Name _____ Middle Name _____ Last Name _____

Date of Birth_____ Sex ☐Male ☐Female Social Security # _____

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____Cell Phone ( )_____Primary Care Physician_____

Father's Name_____
SSN_____ DOB_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell #_____
Employer_____
Occupation_____ Race _____
Employment status_____
Address _____
Work Phone _____
Email Address_____

Mother's Name _____
SSN_____DOB _____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell #_____
Employer_____
Occupation_____ Race _____
Employment status_____
Address _____
Work Phone _____
Email Address_____

Emergency Contact (**SOMEONE THAT DOES NOT LIVE IN THE HOME**)

Name _____ Home Phone ( )_____ Cell _____
Address_____ City_____State_____ Zip_____
Employer _____ Work Phone ( )_____
Relationship to Patient _____

Primary Insurance

Insurance Co_____
Policyholder's Name_____
Address _____
Effective Date _____
ID # _____
Group # _____

Secondary Insurance

Insurance Co _____
Policyholder's Name _____
Address _____
Effective Date _____
ID # _____
Group # _____

Choice of Pharmacy _____

Update (office use only)_____ _____ _____

OVER ⇨

AUTHORIZATION INFORMATION

I request payment of authorized benefits be made on my behalf to the provider for any services furnished for me. I authorize my holder of medical information to release to insurance carriers any information needed to determine benefits payable for services provided. I further authorize the release of necessary information and medical records as required to assure continuity of care with other health care providers, for reimbursement or for accreditation purposes.

I am responsible to pay for all services received, regardless of my insurance coverage, I am responsible for my co-pay or 20% at time of service.

I authorize the release of medical information to the following family members (if none, write none in the first blank):

_____ _____

_____ _____

_____ _____

_____ _____

Signature Date

AUTHORIZATION FOR TREATMENT

I hereby give consent to the Avera Medical Group Pediatrics's physicians, mid-levels and staff for medical treatment, diagnostic and/or surgical procedures.

_____ _____

Signature Relationship to Patient Date

Ethnicity: ☐Caucasian ☐Native American ☐African American
☐Hispanic ☐Other_____

Language: ☐English ☐Spanish ☐Other_____

ABOUT OUR NOTICE OF PRIVACY PRACTICES
at Avera Medical Group Pediatrics Mitchell

In Compliance with the law, we are committed to protecting your personal health information.

The Attached Notice of Privacy Practices state:

- **Our obligations under law with respect to your personal health information.**
- **How we may use and disclose the health information that we keep about you.**
- **Your rights relating to your personal health information.**
- **Our rights to change our Notice of Privacy Practices.**
- **How to file a complaint if you believe your privacy rights have been violated.**
- **The conditions that apply to uses and disclosures not described in this Notice.**
- **The person to contact for further information about our privacy practices.**

We are required by law to give you a copy of this Notice and to obtain your written acknowledgement that you have received a copy of this Notice.

PATIENT ACKNOWLEDGMENT OF RECEIPT

I, _____, (parent) hereby acknowledge that I have received a copy of the Notice of Privacy Practices at Avera Medical Group Pediatrics Mitchell.

Patient's Name **Relationship to Patient** **Date**

Signature of Parent or Patient's Representative (If applicable) **Relationship to Patient** **Date**

DOCUMENTATION OF GOOD FAITH EFFORTS

- ❑ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient parent legal guarding declined to acknowledge the receipt of the Notice of Privacy Practices.
- ❑ The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.
- ❑ Other _____.

_____ _____

Witness **Date**

(REV 6/11, 7/11, 8/12)