MOUNTAIN LAND
PEDIATRICS

Please print legibly in blue or black in

How did you hear about us? (Please circle one): (Friend/Family) (Colorado Parent Magazine) (Community Event) (Thornton or Westminster Recreation Center) (Website Search) (Insurance Provider or Website) (Yellow Pages) (Adams County) (Other) please specify_____

Email Address for Account_____

Would you like to receive information about pediatric programs and wellness for your child? Yes No (Please circle one)

Full Legal Names of ALL Children that will be patients (oldest to youngest):

First Name	*Middle*	*Last Name*	*Male / Female*	*Date of Birth*	*Live With*	*Foster Child? Y/N*

Mother/Guardian of Child _____ Date of Birth_____ SSN# _____

Address _____ City _____ State _____ ZIP Code_____

Phones: Home_____ Work _____ Cell _____

Employer _____ Position_____ Length of time at job_____

Father/Guardian of Child _____ Date of Birth_____ SSN# _____

Address _____ City _____ State _____ ZIP Code_____

Phones: Home_____ Work _____ Cell _____

Employer _____ Position_____ Length of time at job_____

Financially Responsible Party (Parent or Guardian)_____

Name of Emergency Contact _____ Phone _____

Former Pediatrician _____

Primary Language Spoken by child(ren)_____ Primary Language Spoken by Parents _____

Race (Please Circle) (American Indian/Alaskan) (Asian) (Black/African American) (Native Hawaiian/Pacific Islander) (White) (Hispanic / Latino) (Mixed_____) (Decline) If Hispanic/Latino(Please Circle) (Mexican) (Cuban) (Puerto Rican) (Other_____)

Patient has State of Colorado Medicaid: (circle) YES or NO PRIMARY or SECONDARY

Insurance Coverage Information

Insurance card must be presented at each visit

Primary Insurance:

Effective Date: _____ Today's Date: _____

Insurance Company: _____ Co-pay: _____

Policy Holder (Guarantor): _____

Guarantor's Social Security #: _____ Date of Birth: _____

Insurance Policy/ID #: _____

Insurance Group #: _____

Employer: _____

Employer Phone #: _____

Insurance Address: _____

Insurance Phone Number: _____

Names of Children on this policy:

- _____
- _____
- _____
- _____

Secondary Insurance:

Insurance Company: _____ Co-pay: _____

Policy Holder: _____

Guarantor's Social Security #: _____ Date of Birth: _____

Insurance Policy/ID #: _____ Insurance Group: _____

Employer: _____ Employer Phone #: _____

Insurance Address: _____

Insurance Phone Number: _____

Names of Children on this policy: _____

The above information is current and correct. I understand that I am financially responsible for all charges incurred whether or not paid by insurance.

Signature: _____ Date: _____

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AUTHORIZATION FOR CHILD'S TREATMENT

I, (We)_____ am(are) the parent/guardian of:

NAME:_____DOB:_____

NAME:_____DOB:_____

NAME:_____DOB:_____

NAME:_____DOB:_____

NAME:_____DOB:_____

I hereby give Mountainland Pediatrics specific authorization to treat my child, including authorization to administer immunizations when my child is brought to the practice by any of the following caregivers.

I further authorize the practice to triage or discuss with the designated caregivers, either in person or by phone, my child's symptoms and/or medical condition in order to assist and advise the caregiver concerning the immediate treatment options for my symptomatic child. This includes releasing relevant medical information to the caregiver, on a need-to-know basis.

Please indicate name and relationship to patient:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

_____ _____

Parent/Guardian Date

8889 Fox Drive, Suite A • Thornton, Colorado 80260-8823
303-430-0823 • Fax 303-426-9581

MOUNTAINLAND
PEDIATRICS

Full Legal Names of ALL Children who will be patients (oldest to youngest)

First Middle Last M/F Date of Birth

- _____
- _____
- _____
- _____
- _____

Method of Contact

I give permission to Mountainland Pediatrics to leave a phone message with information regarding my child's medical care at the number(s) listed below.

Primary phone number _____

Secondary phone number _____

Acknowledgement of Receipt of Notice of Privacy Rights

I have received a copy of Mountainland Pediatrics privacy rights. _____initial

Returned Checks

When you provide us a check as payment you authorize us to use the information from the check to make a one- time electronic fund transfer from your account, or to process the payment as a check transaction. Returned checks are assigned to PFC Check Solutions and electronically re-presented through ETP (Electronic Transaction Partners) for the face amount plus a $20.00 Service Charge an all applicable costs of collection pursuant to C.R.S. 13-21-109.

Acknowledgement of Receipt of Mountainland Pediatrics Financial and Office Policies Document

I have received a copy of Mountainland Pediatrics Financial and Office Policies. _____initial

As of _____(date) my signature will be accessible in an electronic format and serve as a legal copy of authorization for services including our Financial and Office Policy.

Signature of parent/guardian:_____

Date:_____