Utah Valley Pediatrics, LLC

UVP PARTICIPATES IN STATE AND FEDERAL PROGRAMS THAT REQUIRE DATA ON RACE AND ETHNICITY.

FAMILY INFORMATION* (FOR ALL PATIENTS) - *Please Use Full Names*

DATE: _____

Legal Guardian 1: _____ Date of Birth: _____ Social Security #: _____

Gender: ☐ Male ☐ Female Relationship To Child(ren): ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Other: _____

Mailing Address: _____ City _____ State _____ Zip _____ Employer: _____

Phone (primary): _____ Phone (alternate): _____ Email: _____

Preferred Language: _____ Do you require an interpreter? ☐ Yes ☐ No

Legal Guardian 2: _____ Date of Birth: _____ Social Security #: _____

Gender: ☐ Male ☐ Female Relationship To Child(ren): ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Other: _____

Mailing Address: _____ City _____ State _____ Zip _____ Employer: _____

Phone (primary): _____ Phone (alternate): _____ Email: _____

Preferred Language: _____ Do you require an interpreter? ☐ Yes ☐ No

***Please note that the information provided in this section will be used to contact you regarding appointment reminders, account balances, and any other medical or billing issues regarding your account. Calls to the number(s) provided may be made via pre-recorded messages.**

CHILDREN INFORMATION (UVP participates in several state and federal programs that require data on race and ethnicity.)

IF 18 OR OLDER, SKIP THIS SECTION AND FILL OUT "PATIENTS 18 OR OLDER" SECTION BELOW.

1. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race**: ☐ Am. Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White Other: _____

2. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race**: ☐ Am. Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White Other: _____

3. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race**: ☐ Am. Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White Other: _____

4. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race**: ☐ Am. Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White Other: _____

5. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race**: ☐ Am. Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White Other: _____

6. Child's Full Name: _____ Date of Birth: _____ Goes by: _____
Sex: ☐ Male ☐ Female **Race**: ☐ Am. Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White Other: _____

PATIENTS 18 OR OLDER ONLY* (THIS SECTION TO BE COMPLETED BY PATIENTS 18 YEARS OR OLDER)

DATE: _____

Full Name: _____ Goes by: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Social Security # _____ Race: _____ Preferred Language: _____ Do you require an interpreter? ☐Yes ☐No

Mailing Address: _____ City _____ State _____ Zip _____ Employer: _____

Phone (primary): _____ Phone (alternate): _____ Email: _____

Marital Status: ☐ Married ☐ Single ☐ Other

***Please note that the information provided in this section will be used to contact you regarding appointment reminders, account balances, and any other medical or billing issues regarding your account. Calls to the number(s) provided may be made via pre-recorded messages.**

PERSON RESPONSIBLE FOR INSURANCE (PRIMARY)

Policy Holder: _____

Home Address: _____

City: _____, State: _____, Zip: _____

Phone: _____

DOB: _____, Relationship to patient: _____

PERSON RESPONSIBLE FOR INSURANCE (SECONDARY)

Policy Holder: _____

Home Address: _____

City: _____, State: _____, Zip: _____

Phone: _____ _____

DOB: _____, Relationship to patient: _____

EMERGENCY CONTACT (This person should live in the same state, but not in the same household)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

(CONTINUED ON BACK)

PHARMACY INFORMATION

Name of Preferred Pharmacy: _____ Location: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Utah Valley Pediatrics' NOTICE OF PRIVACY PRACTICES and that it is my responsibility to read said notice to understand how my or my child(ren)'s Protected Health Information (PHI) may be used. I understand that no authorization is required from me in order for UVP to use my or my child(ren)'s PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization.

☞ **Patient (If 18 years or older) / Legal Guardian Signature**: _____Date: _____

NOTIFICATION OF APPOINTMENTS/TREATMENT

Utah Valley Pediatrics makes every effort to use your preferred method of communication for appointment/treatment reminders and/or any other issues regarding your account with us. Contact with you may be made using the information you have provided, and may consist of text messages, voicemail, e-mail, letters, etc. If you choose not to be contacted via one of the methods listed above you must notify UVP in writing. Every effort will be made to respect your request**. Please check your preferred method(s) of communication** (any that apply): □ E-mail □Text □ Voicemail

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES / AUTHORIZATION TO TREAT IN THE ABSENCE OF PARENT/GUARDIAN

In my absence, I authorize UVP to release all or portions of my, or my dependent's, medical and/or billing records to those as indicated below (i.e. lab results, prescriptions, etc.), and/or consent for my child to be treated when brought into the office by the authorized individuals as listed below (Please consider extended family members, step-parents, daycare providers or, if you are 18 or older, your parents). I understand that I am still financially responsible for the cost of such care. This authorization is in effect until I revoke it in writing.

Name: _____ ☐ All, or ☐ Treatment in Absence ☐ Lab Result ☐ Prescription ☐ Billing

Name: _____ ☐ All, or ☐ Treatment in Absence ☐ Lab Result ☐ Prescription ☐ Billing

Name: _____ ☐ All, or ☐ Treatment in Absence ☐ Lab Result ☐ Prescription ☐ Billing

Name: _____ ☐ All, or ☐ Treatment in Absence ☐ Lab Result ☐ Prescription ☐ Billing

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____Date: _____

CONSENT FOR TREATMENT

I hereby consent to medical treatment, diagnostic tests, laboratory or other procedures, which the physician(s) or other health care provider(s) of UVP may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

☞ **Patient (If 18 years or older) / Legal Guardian Signature:** _____Date: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I agree to be financially responsible for costs incurred in my, or my dependent's, care. I understand that charges for services provided shall be paid for at the time of each visit. I hereby authorize any benefits due me to be paid directly to UVP (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third-party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits. A finance charge (1.5% per month/APR 18%) will be added to any amount for which payment has not been received within **30 days** from the date of the statement on which the amount first appears. I hereby agree to pay a service charge up to the amount allowed by law for each check or other instrument tendered by me but returned to this facility. In the event any amounts are referred to a third-party debt collection agency, I agree that in addition to any other amounts allowed by law (interest, court costs, attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount owing as allowed by Utah Code Annotated section 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today. I hereby consent to receiving manually dialed and/or auto dialed calls and/or text/SMS messages (which may include artificial or pre-recorded collection and/or healthcare related messages) to my wireless/cellular number and any other telephone number(s) provided or obtained during any interaction, agreement, or communication with UVP and/or its affiliates, agents, contractors and assignees, including but not limited to any account management/billing company(ies) and/or third-party collection agency(ies) and their respective agents.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of UVP's financial policy and agree to pay for said medical services according to such terms.

☞ **Patient (If 18 years or older) / Legal Guardian Signature**: _____Date: _____

NO-SHOW POLICY AND AGREEMENT

I acknowledge that I have received a copy of Utah Valley Pediatrics' No-Show Policy and understand that I will be charged a no-show fee for any missed appointments, including those not canceled in a timely manner as outlined in the policy. No-show charge amounts will be posted at the front desk. I understand that these charges are not covered by my insurance company and will be my sole responsibility as the guarantor / responsible party on the account.

☞ **Patient (If 18 years or older) / Legal Guardian Signature**_____ **Date:** _____