Children's of Alabama

Over The Mountain Pediatrics

Revised 04/23/2018

Primary Physician (check one) ___Baxley ___Conry ___Dennis ____Hodges ___Luke ___Menendez ___Wilson

List all patients' legal names (in this family) to be seen by us:

_____ Male Female Pt cell_____
First Middle Last Name Nickname Date of Birth

_____ Male Female Pt cell_____
First Middle Last Name Nickname Date of Birth

_____ Male Female Pt cell_____
First Middle Last Name Nickname Date of Birth

_____ Male Female Pt cell_____
First Middle Last Name Nickname Date of

Father's Legal Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City**_____ **State**_____ **Zip**_____

Phone # ( ) _____ **Cell Phone #** ( ) _____ **Work Phone #** ( ) _____

Employer: _____ Occupation: _____

Email: _____ **Primary Language:** _____

Race (please check one) ___American Indian/Alaska Native ___Blk/African American ___Nat Hawaiian/Pacific Islander ___ Asian ___White ___Other ___ Declined

Ethnicity (please check one) ___Hispanic/Latino ___ Not Hispanic/Latino ___Unknown ___Declined

Mother's Legal Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City**_____ **State**_____ **Zip**_____

Phone # ( ) _____ **Cell Phone #** ( ) _____ **Work Phone #** ( ) _____

Employer: _____ Occupation: _____

Email: _____ **Primary Language:** _____

Race (please check one) ___American Indian/Alaska Native ___Blk/African American ___Nat Hawaiian/Pacific Islander ___ Asian ___White ___Other ___ Declined

Ethnicity (please check one) ___Hispanic/Latino ___ Not Hispanic/Latino ___Unknown ___Declined

Primary Insurance Co: _____ Card holder's name _____ DOB:_____ _____

Policy Number_____ Group Number: _____ Effective date: _____

Secondary Insurance Co: _____ Card holder's name _____ DOB:_____

Policy Number_____ Group Number: _____ Effective date: _____

Emergency Contact: _____ **Relationship to patient (s)** _____
Phone # ( ) _____ **Cell Phone #** ( ) _____ **Work Phone #** ( ) _____

PLEASE READ THE FOLLOWING VERY CAREFULLY

Consent for treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants.

Authorization for release of medical records and insurance information: I hereby authorize the release of any or all medical records including psychiatric, drug alcohol, substance abuse and any and all financial and accounting records, including insurance information to referring physicians or agencies from whom the patient seeks medical care.

Assignment of benefits and guarantee of account: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. This includes a $25 fee for missed appointments. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all cost of collection including attorney's fees; all court cost if any and a $25.00 collection fee.

Consent to contact for information/reminders: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Over The Mountain Pediatrics to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Divorced Parents: In keeping with our policy that payment is due at the time service is rendered, it is the person who brings the patient to us who is responsible for payment and who should sign as responsible party.

Date: _____ **Responsible Party's Signature** _____