Over the Mountain Pediatrics

Primary Physician (circle one): Baxley Conry Dennis Hodges Menendez Stone Wilson

List patients (in this family) to be seen by us:

Name ____ M F Birth Date______________

Name ____ M F Birth Date______________

Name ____ M F Birth Date______________

Name ____ M F Birth Date______________

Father's Legal Name: ____ Date of Birth: ____________

Race: (Please check) ___ American Indian/Alaska Native ___ Black/African American ___ Nat Hawaiian/Pacific Islander
___Asian ___ White ___ Other ___ Declined

Ethnicity: (Please check) ___Hispanic/Latino ___Not Hispanic/Latino ___Unknown ___Declined

Primary Language: __________________________ Email address: ____

Mailing Address: ____
City _________________________State___________ Zip____________

Home Phone # ( ) _______________ Cell Phone # ( ) ________________ Work Phone # ( ) _______________

Employer _____________________________________ Address ____

Mother's Legal Name: ____ Date of Birth: ____________

Race: (Please check) ___ American Indian/Alaska Native ___ Black/African American ___ Nat Hawaiian/Pacific Islander
___Asian ___ White ___ Other ___ Declined

Ethnicity: (Please check) ___Hispanic/Latino ___Not Hispanic/Latino ___Unknown ___Declined

Primary Language: __________________________ Email address: ____

Mailing Address: ____
City _________________________State___________ Zip____________

Home Phone # ( ) _______________ Cell Phone # ( ) ________________ Work Phone # ( ) _______________

Employer _____________________________________ Address ____

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. 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 and all court cost if any.
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 ____

Revised 02/16/2015