La Altura Pediatrics
Dominion Hills Plaza
21195 IH-10 West, Suite 2101
San Antonio, TX 78257

Patient Demographic Information

Name:_____ _____ Date of Birth:_____

Gender : Male___ Female___ Social Security Number_____

Address:_____

*Race:_____ *Ethnicity_____ *Preferred Language_____

Patient's Mother

Name:_____ Date of Birth:_____

Primary Phone:_____ Secondary Phone:_____

Address (If Different From Above):_____

Employer:_____ Work Phone:_____

Email Address:_____

Emergency Contact:_____

Patient's Father

Name:_____ Date of Birth:_____

Primary Phone:_____ Secondary Phone:_____

Address (If Different From Above):_____

Employer:_____ Work Phone:_____

Email Address:_____

Emergency Contact:_____

*Requirement under the Healthcare Reform Act

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Insurance

Primary Subscriber Name:_____

Subscriber's Date of Birth:_____ Subscriber's SSN:_____

Employer:_____ Relation To Patient:_____

Insurance Company Name:_____

Policy #:_____ Group #:_____

Patient's Relationship to policy holder? ___Self ___Spouse ___Child ___Other:_____

Secondary Subscriber's Name:_____ Secondary Subscriber's DOB:_____

Secondary Insurance Name: _____

Secondary Policy #:_____ Secondary Group #:_____

Patient's Relationship to policy holder? ___Self ___Spouse ___Child ___Other:_____

Pharmacy

Preferred Pharmacy Name: _____

Phone Number:_____

Address (or cross streets):_____

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Payment & Treatment Agreement

I acknowledge that payment is due that time of service and that charges may vary according to the type and extent of services provided. I understand that I am financially responsible for all services rendered, regardless of insurance coverage. I hereby authorize for payment of benefits directly to La Altura Pediatrics for services rendered, for release of any information necessary to process claims, and for use of this signature on all insurance submissions. An electronic or photo copy of this document is considered valid as the original.

Signature: _____ Date: _____

1. I consent to services, treatment and diagnostic procedures, including but not limited to medications and lab tests which may be ordered by my provider at La Altura Pediatrics.
2. I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent I assign all rights, title and interest and authorize direct payment to the La Altura Pediatrics of any insurance benefits or benefits under the Social Security Act for the services. La Altura Pediatrics will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment. I authorize La Altura Pediatrics to bill my insurance or third party payor and receive payment from them directly.
3. I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, La Altura Pediatrics may disclose my records to any person, Social Security Administration, insurance or benefit payor, health care service or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges. Furthermore La Altura Pediatrics may disclose my records to other treating providers, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.
4. My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signature: _____ Date:_____
(Patient, Parent or Guardian)

Relationship to Patient:_____ Date:_____

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PARENT/GUARDIAN CONSENT FOR TREATMENT OF MINOR

Minor Accompanied by Another Adult

I, _____, parent or legal guardian of _____, born on _____, do hereby consent to any medical care and treatment determined by a physician or nurse practitioner of La Altura Pediatrics to be necessary for the welfare of my child while said child is under the care of _____. This authorization will remain in effect until revoked by the parent or legal guardian.

Unaccompanied Minor

I, _____, parent or legal guardian of _____, born on _____, do hereby consent to any medical care and treatment determined by a physician or nurse practitioner of La Altura Pediatrics to be necessary for the welfare of my child while said child arrives unaccompanied. This authorization will remain in effect until revoked by the parent or legal guardian..

_____ _____

Signature Date