UPPER VALLEY PEDIATRICS, PLLC

All Information Is Required, Thank you. Please note, pages are 2 sided

Patient Name (Full Legal Name): _____

Date of Birth: _____

Gender: _____

Hearing/Vision Impairment: _____

Race: (Please check one)

American Indian		White	
Asian		Prefers Not to Answer	
Black/African American		Other: (Please explain below)	
Pacific Islands			

Ethnicity: (Please check one)

NOT Hispanic or Latino	
Hispanic or Latino	
Prefers Not to Answer	

Preferred Language: _____

PARENT/LEGAL GUARDIAN INFORMATION

Name:	Name:
Relationship to Pt:	Relationship to Pt:
Mailing Address: Physical Address:	Mailing Address: Physical Address:
City:	City:
State & Zip Code:	State & Zip Code:
Primary Phone #:	Primary Phone #:
Email Address:	Email Address:
Other Phone #:	Other Phone #:
Children primarily reside with? _____ **Billing Account Primary? Y or N** **Primary contact for scheduling? Y or N**	**Children primarily reside with? _____** Billing Account Primary? Y or N Primary contact for scheduling? Y or N

Communication Preference for Appointment Confirmation**: PLEASE list one below**

Ph Call # _____ Text # _____ Email _____

Insurance/Payments/Fees

Please note: Copays are due at Check-In every visit unless other arrangements have been made

Primary Insurance Information:

INS Company:	**Insurance ID:**
Policy Holder Name:	**Copay Amount:**
Policy Holder's Employer:	**Policy Effective Date:**
Policy Holder's DOB:	**Insurance Group #:**

Secondary Insurance Information:

INS Company:	**Insurance ID:**
Policy Holder Name:	**Copay Amount:**
Policy Holder's Employer:	**Policy Effective Date:**
Policy Holder's DOB:	**Insurance Group #:**

To what address should bills and/or correspondence be sent?

PLEASE PROVIDE 24 HOURS ADVANCED NOTICE FOR CANCELLING A SCHEDULED VISIT.

MISSED OR LATE CANCELLED VISITS WILL RESULT IN A FEE OF 25$ OR 50$ DEPENDENT UPON VISIT TYPE/ LENGTH

AUTHORIZATION AND RELEASE: I authorize the providers of Upper Valley Pediatrics (UVP) to assess and treat the above-named patient(s). I also authorize UVP to release any information including diagnosis/treatment/examination rendered during the period of such care to third party payors and/or health providers. I authorize and request that my insurance company pay directly to UVP the benefits otherwise payable to me. I understand that my insurance carrier may not cover all services provided or ordered. I agree to be responsible for the payment of all services rendered on behalf of the above-named dependents. *In accordance with Upper Valley Pediatrics Financial Policy.

DATE: _____

SIGNATURE: _____

MEDICAL TREATMENT AUTHORIZATION & CONSENT FORM

PATIENT: _____ DOB: _____

The following portion of this form is designed for situations where minors are not accompanied by a parent/legal guardian but parent/legal guardian's gives consent to designate a specified adult to arrange for medical care of the above-named minor (i.e. grandparent, other relative, daycare provider). This is extremely important, in that, medical care cannot be provided to a minor without approval &/or written consent by the parent/legal guardian. The undersigned hereby authorizes the below designated individual(s) to consent to any medical evaluation, diagnosis, or treatment for the above-named minor, which is deemed advisable by, and to be rendered by, a physician/ provider of U.V.P.

[Parental consent must still be obtained for the administration of any vaccinations]

_____ _____

Designated/Authorized Individual Relationship

_____ _____

Designated/Authorized Individual Relationship

AUTHORIZED BY:

_____ _____

Parent/Legal Guardian Signature Date

MEDICAL TREATMENT AUTHORIZATION & CONSENT FORM

PATIENT: _____ DOB: _____

As parent/legal guardian of the above patient I hereby authorize the above indicated minor to attend office visits unaccompanied by a parent/guardian. The undersigned hereby authorizes consent to any medical evaluation, diagnosis or treatment for the above-named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician/provider of U.V.P. in my absence.

Any limitations on services provided or special requests (i.e. communication by phone prior to &/or after provision of services) will be detailed below.

*Specific Limitations and/or Requests:

_____

_____

_____

[Parental consent must still be obtained for the administration of any vaccinations]

_____ _____

Parent/Legal Guardian Signature Date

FOSTER CARE PROVIDER/LEGAL GUARDIAN INFORMATION

NAME:

RELATIONSHIP:

MAILING ADDRESS:

CITY

STATE & ZIPCODE:

PRIMARY PHONE NUMBER:

EMAIL ADDRESS:

OTHER METHOD OF CONTACT:

We MUST retain copy of legal documentation/court orders

Date foster care began:	
Expected length of care:	

INDICATE IF INFORMATION SHARING IS TO BE RESTRICTED- PROVIDE PARTIES NAMES AND DETAILS

EX: Biological Mother, JANE DOE- No contact allowed, is not to be provided any information

Case worker Information:

Case Worker's Name:	Phone #:
DCF Office:	Phone #: