**Upper Valley Pediatrics, PLLC**
**New Patient Intake**

Patient Full Name: _____ Date of Birth: _____

Gender: _____ Hearing/Vision Impairment: _____

Patient Full Name: _____ Date of Birth: _____

Gender: _____ Hearing/Vision Impairment: _____

Patient Full Name: _____ Date of Birth: _____

Gender: _____ Hearing/Vision Impairment: _____

Patient Full 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: _____

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

Phone Call: _____ Text: _____

Would you like to enroll in our Patient Portal ? YES NO

## PARENT/LEGAL GUARDIAN INFORMATION

| | |
|---|---|
| Name: | Name: |
| Relationship to Patient: | Relationship to Patient: |
| Mailing Address:<br><br>Physical Address: | Mailing Address:<br><br>Physical Address: |
| City: | City: |
| State & Zip Code: | State & Zip Code: |
| Primary Phone: Mobile or Landline | Primary Phone: Mobile or Landline |
| Email: | Email: |
| Other Phone: | Other Phone: |
| Billing account primary ?<br>YES NO<br><br>Primary contact for scheduling?<br>YES NO | Billing account primary ?<br>YES NO<br><br>Primary contact for scheduling?<br>YES NO |

## Insurance/Payment/Fees

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

**Primary Insurance Information:**

| | |
|---|---|
| **INS Company:** | **Subscriber ID:** |
| **Policy Holder Name:** | **Group ID:** |
| **Policy Holder's Employer:** | **Policy Effective Date:** |
| **Policy Holder's DOB:** | |

**Secondary Insurance Information:**

| | |
|---|---|
| **INS Company:** | **Subscriber ID:** |
| **Policy Holder Name:** | **Group ID:** |
| **Policy Holder's Employer:** | **Policy Effective Date:** |
| **Policy Holder's DOB:** | |

**What address should bills be sent to ?**

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

**MISSED OR SAME DAY CANCELLATIONS WILL RESULT IN A MISSED APPOINTMENT OR SAME DAY CANCELLATION FEE.**

**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 may insurance companies 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.**

**Signature: _____ Date: _____**

## Medical Representative Consent

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 give consent to designate a specific adult to arrange medical care of the above-named minor (i.e, grandparents or other relatives). Parental/Legal Guardian consent must still be obtained for the administration of any vaccines.

**I hereby give my consent for my child to be brought to medical appointments by another designated adult. I authorize this adult to accompany my child during visits, participate in discussions regarding my child's care, and receive relevant medical information as necessary for the purpose of the appointment. This authorization includes access to my child's protected health information related to diagnosis, treatment, and care coordination. I understand that this consent remains in effect unless revoked by me in writing.**

**Authorized Individual: _____ Relationship:_____**

**Phone Number: _____**

**Authorized Individual: _____ Relationship:_____**

**Phone Number: _____**

**Authorized Individual: _____ Relationship:_____**

**Phone Number: _____**

**Authorized Individual: _____ Relationship:_____**

**Phone Number: _____**

**AUTHORIZED BY:**

_____ _____

**Parent/Legal Guardian Signature** **Date**

## Unaccompanied Minor Visit Consent

This consent form allows a parent or legal guardian to authorize a minor patient to attend medical appointments without a parent or guardian present, including arriving independently (for example, driving themselves to appointments). By completing this form, you are giving permission for Upper Valley Pediatrics to provide medical care to your child during these visits. This consent also acknowledges that certain aspects of a minor's care and access to medical information are governed by state minor consent and privacy laws in Vermont and New Hampshire. Parents and guardians are encouraged to review these laws for additional details regarding consent, confidentiality, and access to health information.

**I hereby give consent for my minor child to attend medical appointments without a parent or legal guardian present.**

**I authorize Upper Valley Pediatrics to provide medical evaluation, treatment, and care as deemed appropriate during these visits.**

**I understand that certain services may be provided in accordance with applicable minor consent laws in Vermont and New Hampshire, which may limit parental access to specific health information.**

**I acknowledge that I am responsible for reviewing and understanding these laws as they apply to my child's care.**

**I understand that visit summaries, test results, and other available information may be accessed through the patient portal, subject to state and federal privacy regulations.**

**I acknowledge that I remain financially responsible for services provided, and that this consent remains in effect unless revoked by me in writing.**

**AUTHORIZED BY:**

_____ _____

**Parent/Legal Guardian Signature** **Date**