Hometown PEDIATRIC CARE

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****Please list ALL children under the age of 19 that are active patients in our office****

Child 1: Last Name _____ First Name _____ Middle Initial _____

DOB _____ Gender _____

Child 2: Last Name _____ First Name _____ Middle Initial _____

DOB _____ Gender _____

Child 3: Last Name _____ First Name _____ Middle Initial _____

DOB _____ Gender _____

Child 4: Last Name _____ First Name _____ Middle Initial _____

DOB _____ Gender _____

Mother/Guardian: Name _____ DOB _____

Primary Phone (_____) _____ Mailing address _____

Employer _____ Work phone (_____) _____

Father/Guardian: Name _____ DOB _____

Primary Phone (_____) _____ Mailing address _____

Employer _____ Work phone (_____) _____

Patient resides with: ☐ Mom ☐ Dad ☐ Both

Primary phone number to receive appointment reminders by **text** (_____) _____

Primary **email** address _____

Emergency contact that does not live in your household _____

Relationship to patient _____ Phone (_____) _____

The following individuals are knowledgeable about my child's health and history therefore I authorize them to bring my child for his/her medical treatments, check ups and/or immunizations

Name _____Relationship to patient _____

Name _____Relationship to patient _____

Missed Appointment/Late Cancellation Policy

Our goal is to provide our patients with high quality healthcare in a timely manner. Late arrivals, missed appointments and late cancellations inconvenience not only our providers, but other patients as well. Appointment times are in high demand and your advance cancellation notice will allow another patient access to that appointment time.

Please be aware of our policy regarding missed appointments and late cancellations

Parents must cancel or reschedule appointments at least 24 hours in advance. Failure to do so will result in a "missed appointment/late cancellation" fee of $50.00 per occasion per child to be added to the child's account. This fee must be paid in full prior to scheduling another appointment. Continued instances of not coming to scheduled appointments and/or late cancellations may result in the office requiring that you find another doctor.

Appointments can be canceled by calling the office at 361-579-1333 between the hours of 8:30am to 4:30pm Monday thru Thursday and 8:30am to 2:30pm on Friday. If necessary, you may leave a detailed voicemail message and we will return your call as soon as possible. If the office is closed, our answering service will take your message.

All Missed Appointment/Late Cancellation fees are the sole responsibility of the patient's guardian and must be paid in full before the next scheduled appointment

Please sign below confirming that you have read, understand and accept the above office policies.

_____

Parent Signature Date

You MUST provide a copy of your insurance card (front and back) for billing purposes

Primary Insurance: _____ ID#_____ Group#_____

Policy Holder Name: _____ DOB _____

Secondary Insurance: _____ ID#_____ Group#_____

Policy Holder Name: _____ DOB _____

***** MANDATORY FOR ALL PATIENTS – NO EXCEPTIONS*****

As a courtesy, we will verify insurance eligibility at your child's initial visit and any time you notify us of a change in your coverage. As the card holder of the insurance policy, you are ultimately responsible for knowing what your plan does and does not cover (like check ups and immunizations). You are also responsible for verifying that our providers participate in your insurance plan. Any amounts not covered by your plan, except for contractual fee discounts, are your financial responsibility. Co-pays and coinsurance/deductible amounts are due at each visit. We do not accept or file any Medicaid plans. Please initial below confirming that you have read, understand and accept the above financial policy and authorize the payment of medical benefits to Stephen M. Dentler, DO for services rendered.

_____ **Initial**

A physician assistant and pediatric nurse practitioner are on staff in this clinic in order to assist in the delivery of medical care to our patients. This includes but is not limited to; alternating well child check ups with the physician, school physicals, treatment of acute injuries and treating acute and chronic illnesses. Physician assistants and nurse practitioners are not doctors, but are graduates of an accredited training program that is licensed by the State Board of Health. Our physician assistant and nurse practitioner work under the direct supervision and guidance of our physicians and can diagnose, treat, monitor acute and chronic diseases and provide health maintenance care. Please initial below confirming that you give your consent to the services of our physician assistant and/or nurse practitioner for your child's healthcare needs.

_____ **Initial**

This office follows the immunization guidelines set forth by the American Academy of Pediatrics and the American Council on Immunization Practices. For the safety of those families who choose to immunize their infants, we will no longer diverge from the recommended schedule, nor will we continue to see families who choose not to vaccinate their infants.
We do not administer the Covid-19 Vaccine. Educational materials are available upon request to support the vast scientific evidence disproving any link between vaccinations and the onset of developmental disorders. Please initial below confirming that you have read, understand and will accept the above vaccination policy.

_____ **Initial**

An important aspect of having quality providers in the future involves opening our practice to individuals going through the training process. We periodically host medical students, Physician Assistant and Nurse Practitioner students. All of which are obligated to conform to HIPPA privacy policies and may be involved in the care of our patients. Students will not perform care independently, all patients will be assessed by a staff provider in addition to any exam performed by a student. Please initial below confirming that you have read, understand and accept the above policy regarding the periodic possibility of a student examining your child in addition to a staffed provider.

_____ **Initial**

We are required to provide you with a copy of our Notice of Privacy Practices stating how we may use and/or disclose your child's health information. You may request additional copies at anytime. Please initial below confirming that you have been provided the opportunity to receive a copy of this office's Notice of Privacy Practices.

_____ **Initial**

The adult who signs a minor child into our practice on the day of service accepts financial responsibility. Our office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about treatment and payment issues.

_____ **Initial**