NORTHERN NEVADA PEDIATRICS

PATIENT INFORMATION Please print / *INFORMACION* DEL PACIENTE

First Name/Middle Initial/LastName:_____
Nombre del paciente/Segundo Nombre/Apellido
Birth Date:_____/_____/_____ Sex: M F
Fecha de Nacimiento: Sexo
Address:_____
Direccion
CITY:_____ STATE:_____ ZIP CODE:_____
Ciudad Estado C. Postal
PRIMARY PHONE:_____ **SECONDARY** PHONE:_____
Telefono Principal Telefono Secundario

OTHER CHILDREN/ Otros hijos en la familia:

NAME/Nombre	DOB/Fecha de Nacimiento	Sex/Sexo
_____	_____	M F
_____	_____	M F
_____	_____	M F
_____	_____	M F
_____	_____	M F

MOM'S NAME / NOMBRE DE MAMA

First Name/Middle Initial/Last Name:_____
Nombre de la Madre/Segundo Nombre/ Apellido
Birth Date:_____/_____/_____ SOCIAL SECURITY NUMBER_____
Fecha de Nacimiento Seguro Social
Address:_____
Direccion
CITY:_____ STATE: _____ ZIP CODE:_____
Ciudad Estado C. Postal
PRIMARY PHONE: _____ **SECONDARY** PHONE: _____
Telefono Principal Telefono Secundario
Employer Name: _____ Employer Phone Number_____
Trabajo Telefono de Trabajo

DAD'S NAME OR OTHER PARENT/ NOMBRE DE PAPA O OTRO PADRE

First Name/Middle Initial/Last Name:_____
Nombre del Padre/Segundo Nombre / Apellido
Birth Date:_____/_____/_____ Sex: M F SOCIAL SECURITY NUMBER_____
Fecha de Nacimiento. Sexo Seguro Social
Address:_____
Direccion
CITY: _____ STATE: _____ ZIP CODE: _____
Ciudad Estado C. Postal
PRIMARY PHONE: _____ **SECONDARY** PHONE: _____
Telefono Principal Telefono Secundario
Employer Name: _____ Employer Phone Number_____
Trabajo Telefono de Trabajo

INSURANCE INFORMATION/ INFORMACION SOBRE EL SEGURO

PRIMARY INSURANCE: _____
Primera Aseguranza
SUBSCRIBER'S NAME: _____ Deductible $_____ Copay $_____
Nombre del Asegurado
SOCIAL SECURITY NUMBER _____-_____-_____ DOB: _____
Seguro Social Fecha De Nacimiento

SECONDARY INSURANCE: _____
Segunda Aseguranza
SUBSCRIBER'S NAME: _____ Deductible $_____ Copay $_____
Nombre del Asegurado
SOCIAL SECURITY NUMBER _____-_____-_____
Seguro Social

CONTACTS NOT LIVING WITH YOU/ CONTACTOS QUE NO VIVAN CON USTED

NAME:_____ PHONE:_____
Nombre Telefono
NAME:_____ PHONE:_____
Nombre Telefono

BY SIGNING AND INITIALING BELOW, I AGREE TO THE FOLLOWING:

_____ OUR OFFICE WILL RELEASE ANY INFORMATION REQUIRED TO PROCESS YOUR INSURANCE CLAIM
_____ I AUTHORIZE PAYMENT FROM MY INSURANCE COMPANY TO BE SENT DIRECTLY TO NN PEDIATRICS.
_____ I AGREE TO PAY ALL CO-PAYS,DEDUCTIBLES,AND ACCOUNT BALANCES AT EVERY VISIT. A **$25** FEEWILL BE CHARGED FOR NON-PAYMENT OF CO-PAY AT TIME OF SERVICE.
_____ THE PARENT/GUARDIANWHO ACCOMPANIES MINOR PATIENT IS RESPONSIBLE FOR PAYMENT AT TIMEOF SERVICE
_____ RETURNED CHECKS WILL BE SUBJECT TO A **$25** FEE
_____ A**$25** FEE WILL BE CHARGED FOR APPOINTMENTS THAT ARE NOT KEPT AND NOT CANCELED AT LEAST 24 HOURS BEFORE THE APPOINTMENT
_____ THE ABOVE FEES ARE NOT BILLABLE OR REIMBURSIBLE BY INSURANCE PLAN
_____ I HAVE BEEN GIVEN A COPY OF NORTHERN NEVADA PEDIATRICS PRIVACY PRACTICES
_____ I UNDERSTAND THAT MY SS# IS REQUIRED FOR BILLING PURPOSES, THEREFORE, IF I DO NOT PROVIDE IT, I WILL BE CLASSIFIED AS A "SELF PAY" PATIENT AND WILL BE REQUIRED TO PAY FOR THE VISIT AT THE TIME OF SERVICE
_____ I UNDERSTAND THAT PROVIDING INCORRECT INSURANCE INFORMATION AT THE TIME OF VISIT WILL RESULT IN"SELF PAY" STATUS

AL FIRMAR Y AL INICIAL YO ESTOY DE ACUERDO CON LO SIGUIENTE:

_____NUESTRA OFFICINA VA A COMUNICAR CUALQUIER INFORMACIÓN REQUIERDA PARA PROCESAR SU RECLAMACIÓN DEASURAGANSA
_____ YO AUTORIZO A MI COMPAÑÍA DE ASEGURANSA A QUE ENVIÉ MIS PAGOS DIRECTAMENTE A NNP
_____ YO ESTOY DE ACUERDO A PAGAR MIS CO-PAGOS, DEDUCIBLES Y BALANCES CADA VISITA. UNA CUOTA DE **$25** SE CARGARA POR NO PAGAR EL CO-PAGO EN EL MOMENTO DE SU CITA.
_____ EL PADRE/GUARDIÁN QUE ACOMPAÑE AL PACIENTE ES RESPONSIBLE DE PAGAR AL MOMENTO DE LA CITA
_____ UNA CUOTA DE **$25** SE CARGARA A CHEQUES DEVUELTOS POR SU BANCO
_____ UN CARGO DE **$25** SERÁ APLICADO PARA CITAS QUE NO SE MANTIENEN 0 CANCELADAS AL MENOS 24 HORAS ANTES DE LA CITA
_____ LAS TARIFAS DE ARRIBA NO SON FACTURABLE O REEMBOLSABLE POR SU ASEGURANSA
_____ ME HAN DADO UNA COPIA DE LA PRIVACIDAD DE LA PRACTICA DE NNP
_____ ENTIENDO QUE MI SEGURO SOCIAL ES NECESARIO PARA COBRAR ALA ASEGURANSA POR LO TANTO SI YO NO LO PROPORCIONO SERÉ CLASIFICADO COMO NO ASEGURADO Y DEBERÉ PAGAR POR LA CITA EN EL MOMENTO DEL SERVICIO
_____ YO ENTIENDO SI DOY LA INFORMACION INCORRECTA DE LA ASEGURANSA EN EL DIA DE LA VISITA RESULTARA EN RESPONSABILIDAD MIA

*** DOES YOUR CHILD HAVE MEDICAID? YES OR NO ***

PERMISSION TO RECEIVE TEXT MESSAGE REMINDERS

(Text messaging and data rates may apply)
Cell Phone Number: _____ (Only 1 number may be used)

PLEASE CIRCLE CELL PHONE CARRIER:

AT&T T-MOBILE VERIZON SPRINT ALLTEL BOOST MOBILE C SPIRE CLARO PR CRICKET
METRO PCS OPEN MOBILE PR POWERTEL SUNCOM US CELLULAR VIAERO VIRGIN MOBILE

SIGNATURE: _____ DATE: _____

NORTHERN NEVADA PEDIATRICS

FINANCIAL CONTRACT/AGREEMENT

1. I understand that if I do not pay my account with Northern Nevada Pediatrics in full that my account may be assigned to a collection agency for collections.

2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission that may be as much as 50% of the amount I owe to Northern Nevada Pediatrics. I agree that if my account is assigned to a collection agency, that Northern Nevada Pediatrics may add the amount of the collection agency's commission or fee to the amount that I owe Northern Nevada Pediatrics, and I agree to pay the additional amount.

3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for medical services. I understand, for example, that if the unpaid balance that I owe to Northern Nevada Pediatrics is $1000.00 that Northern Nevada Pediatrics may add up to $500.00 to my account, and I agree to pay the sum of $1500.00 in such event.

4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fee.

_____ _____

Signature of Patient or Guarantor Date