Welcome to Hirsch Pediatrics!
We are delighted to have you join our family.
Please introduce us to your family.

Please sign on last page.

	First	Last	DOB	Nickname
Mom				
Dad				
Child				
Child				
Child				
Child				

Home address: ______________________________

Phone number: ***Mom*** ____________________ ***Dad*** ____________________

E-mail address: ***Mom*** ______________________________

Dad ______________________________

Preferred pharmacy:

____

Insurance information: ______ mom/dad ______

name guarantor employer

What is your child's race?
(check all that apply)
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Black/African American
☐ White
☐ Hispanic
☐ Prefer not to answer

What is your child's ethnicity?
(check one)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer not to answer

What is the primary language spoken in your house?
(check one)
☐ English
☐ Other language ____________________ (Do you prefer handouts in this language? Yes/No)

(Updated 01/2023)

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Acknowledgement of Receipt of Notice of Privacy Practices:

By signing this form, I indicate that I have reviewed the *Hirsch Pediatrics Notice of Privacy Practices* which is available online (www.HirschPediatrics.com) and posted in the waiting room. I can also receive a printed copy if requested.

Acknowledgement of Retail Prescription History Query:

By signing this form, I consent for Hirsch Pediatrics, my pharmacy, and my health insurer permission to collect and disclose information on my child(ren) about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

Authorization for Completing Daycare/School/Camp Forms:

I hereby authorize the use and disclosure of my child's/children's individually identifiable health information as described below. I understand that this authorization is voluntary and is revocable by me in writing, except as described in our Notice of Privacy Practices. Any health information disclosed by Hirsch Pediatrics pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations. Hirsch Pediatrics may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. This will expire in one year unless otherwise specified or revoked. *If you would like to limit the organizations whose forms we will complete, limit certain medical information on the form, or include other pertinent medical information, do not sign this form and we will provide you with a customized authorization form.*

By signing this form, I indicate that I have reviewed the *Authorization for Completing Forms* section and agree to the following for my child(ren):

Authorization to complete the following:	All requested daycare/school/camp forms provided by parent or guardian to Hirsch Pediatrics
Purpose of information use or disclosure:	To allow my child(ren) to participate in daycare or other school/camp activities.
Specific information to be used or disclosed:	All relevant medical information needed to complete the form.

(Updated 01/2023)

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Acknowledgement of Receipt of Hirsch Pediatrics Financial and Office Policy

Thank you for choosing Hirsch Pediatrics as your healthcare provider.

- Due to frequent changes in healthcare insurance coverage, we require that you provide proof of insurance at EACH visit. **If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit.**
- **If we are a participating provider for your insurance, all co pay and coinsurance amounts are due at the time of service.** We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance company we will attempt to help you resolve it. While this dispute is being resolved the balance may be transferred to your personal balance, which must be paid upon receipt of the notice or statement.
- Your insurance policy is a contractual agreement between you and your insurance company, not between this office and your insurance company. This office will file your primary insurance for you as a courtesy and assist you in filing secondary claims. **However, you will be responsible for negotiating any unpaid or disputed claims with your insurance carrier. It is your responsibility to know what services are covered under your policy.** Please present insurance cards for each child at every visit.
- **The parent or adult accompanying a minor is responsible for payment at the time of service.** In the event of a separation or divorce, Hirsch Pediatrics will hold both parents responsible for payment.
- Your child's account will be assessed a $40 fee for any **returned checks**.
- If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Collections Coordinator. Failure to keep those arrangements or resolve any past due accounts will result in referral to a collections agency.
- **If your account becomes past due (more than 60 days from the date of service) we will take the necessary steps to collect this debt.** All accounts sent to the collections agency will also be reported to the credit bureaus.
- **Once an account has been sent to collections we will require cash or credit card payment on the balance prior to future visits. You will also be required to pay in full for any future visits at the time of the visit and will be refunded any payments made from your insurance company. Any family whose account is forwarded to a collections agency may be dismissed from the practice.**
- **Failure to keep a scheduled appointment as well as failure to give at least 24-hour notice for appointment cancellations will result in a $50 charge to the patient's account.** This charge cannot be billed to your insurance company and must be paid in full prior to future appointments. **Three (3) missed or late cancellation of appointments may result in dismissal from the practice.**
- **Prior to your appointment, please check the practice website (www.HirschPediatrics.com) for the most up-to-date office policies and procedures as well as for any changes to the current policies.**

By signing below, I indicate that I have reviewed the *Hirsch Pediatrics Financial Policy* and can receive a copy if requested.

Signature:	**Date:**
______________________________	______________________________

(Updated 01/2023)