Highlands Integrative Pediatrics, PC
2650 18th Street, Suite 100
Denver, CO 80211

Patient Information (Add all children attending HIP)

Child name: _____ Birth date:_____ M/F

Child name: _____ Birth date:_____ M/F

Child name: _____ Birth date:_____ M/F

Child name: _____ Birth date:_____ M/F

Parent Information

Parent 1 name: _____ Parent 2 name:_____

Address 1: _____ Address 2 (if different): _____

_____ _____

Employer:_____ Employer: _____

Occupation:_____ Occupation: _____

Date of Birth:_____ Date of Birth:_____

Social Security No:_____ Social Security No:_____

Home Phone #:_____ Home Phone #:_____

Work Phone #:_____ Work Phone #:_____

Cell Phone #:_____Cell Phone #: _____

Email Address:_____ Email Address: _____

_____ Sign me up for H.I.P Newsletter

Emergency Contact (not living with you)

Name: _____ **Phone #:**_____

Relationship: _____

Home information:

Who lives in your home and what is their relationship to the patient? Any animals in the home?

Does anyone in the home smoke cigarettes? Any exposure to recreational drugs?

When was your home built? Any known lead exposure?

Do you have a carbon monoxide detector in your home? Fire detector?

Do you have any guns in the house? If so, do you have a gun safe?

HIPAA Consent

I understand that a copy of the Privacy Policy is on display at the front desk and I may request a copy of this policy at any time. I also understand if I have any questions about HIPAA or my child's privacy, I may contact Highlands Integrative Pediatrics to discuss my concerns.

Signature _____ Date _____

Treatment Consent and Disclosure

I hereby voluntarily agree to diagnostic procedure(s) and medical treatments which may be administered to or performed on the patient(s) listed above, under the general or special instructions of the attached practitioner's care and service, or the practitioner's designee(s). I further understand that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the result of the treatment at this office. I understand that my attending practitioner encourages me to ask questions and voice concerns about medical care or services and that asking questions and voicing concerns will not compromise my care.

Signature _____ Date _____

Financial Agreement and Assignment of Insurance Benefits

I have called my insurance company prior to my child's first visit to ensure that the HIP practitioners are **in-network**. I understand that I am financially responsible and agree to pay any and all charges that are not paid by insurance or any third party payer. I authorize payment directly to Highlands Integrative Pediatrics, PC for all benefits otherwise payable to me. I understand that if I do not provide all of the requested/necessary information, I will be billed directly for all charges until such information is provided. Should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 35% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

I understand that I must provide individual insurance for my new baby within 30 days of his/her date of birth or will have to pay out-of-pocket until child has his/her own coverage. If my child is covered under Medicaid (this does not include Denver Health Medicaid or Kaiser Medicaid, which HIP does not accept), I understand that I must provide an individual Medicaid number for the child by the time the child is 30 days old or agree to pay out-of-pocket until I am able to provide a number. I also authorize the release of any medical information necessary to process all claims. Failure to comply with this financial policy may result in the following actions: temporary and/or permanent suspension from the practice and referral to a collection agency.

Signature _____ Date _____

TCPA Acknowledgement

I authorize Highlands Integrative Pediatrics, PC, its agents and assignees to contact me by telephone, text, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future. Should I choose to no longer receive messages via an automated system, I agree to notify HIP in writing 4 business days prior to my child's next appointment.

Signature Date

Please initial that you have read and understand the following policies:

____ Cancellation and Walk-in Fees

If you need to cancel or reschedule an appointment, **please contact our office at least 24 hours in advance to avoid a cancellation fee of $35**. This fee may also be implemented for any missed appointments without proper notification. This policy can include any appointments scheduled in advance but mainly pertains to well visit exams and consultations.

We value your time as patients and our providers try very hard to honor appointment times. In order to help keep our providers on schedule, we prefer to schedule all appointments, including sick visits and nurse visits, ahead of time. However, we do realize that emergencies happen and **if you feel as though you need to come in without an appointment, a $25 walk-in fee will be assessed**, in addition to all of the normal fees associated with your visit, **and your child will be seen when a provider is available.**

____ Copayments

Insurance copayments are due at the time that services are rendered**. If HIP does not receive copayment by the close of business on the date of service, a service fee of $5 will be assessed** in addition to the copay amount.

____ Vaccination Policy

We recommend the routine vaccination schedule for children outlined by the CDC and the American Academy of Pediatrics. As the parent or legal guardian, you have the right of refusal of any vaccinations. If you decide on a schedule that differs from the recommended routine schedule, it is your responsibility to be aware of the timing between vaccines and each dose. **Once a vaccine is consented to in the office and drawn up from the vial, the cost of the vaccine is the financial responsibility of patient/guarantor**.

____ Parking

Due to our limited parking spaces, **we request that only one car per family be parked in the designated HIP parking spots** to ensure that families with newborns and other families have access to parking in our lot during normal business hours. If spouses, partners, other family members, or nannies are driving separately, please find street parking.

____ Photography and Filming Policy

In order to ensure the safety and privacy of your child(ren) and our staff, it is our policy that there is **no photography or filming during any procedures**. This includes but is not limited to the following: immunizations, blood draws, suturing/stapling, catheterization, and ear lavage.

____ Identified Voicemail

It is in violation of HIPAA regulations to leave any personal health information on an unidentified voicemail. If you wish to have lab or test results left as a voicemail message, **please ensure your voicemail states your name and that name matches what we have on file as a legal parent/guardian.**

Complementary and Alternative Treatments and Evaluations

I have specifically sought out the services of Highlands Integrative Pediatrics, PC (H.I.P) for the way in which they practice medicine. H.I.P has explained to me and I fully understand the following:

(a) H.I.P provides traditional pediatric care. As such, the doctors at H.I.P will perform the appropriate treatments and evaluations adhering to the traditional pediatrician standard of care.
(b) In certain situations, H.I.P medical providers may suggest you see a complementary practitioner for treatments that may offer additional benefits. However, under no circumstances must you follow this recommendation. If you decide not to follow this suggestion, it will not alter the treatment that H.I.P provides.
(c) In the event that H.I.P suggests a treatment that is not recognized as traditional, you will be fully informed before beginning such treatment and will require an agreement in writing in advance.
(d) Complementary and alternative medicine is not recognized as traditional but is an alternative method. Like any other treatment or medication, complementary and alternative medicine may or may not alleviate or cure the condition(s) for which it is offered. As with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing, as well as other available testing options, including lab work, before deciding whether the work-up and following medical analysis and possible treatment.
(e) H.I.P and its doctors are not affiliated with the complementary practitioners and care centers. H.I.P has no control over the treatment they may provide nor the effects of such treatment.
(f) If you would like to discuss the treatment being offered by complementary practitioners, a H.I.P doctor will answer any questions you may have.
(g) The federal government, including Medicare and Medicaid, and most insurance companies, do not generally pay or reimburse for alternative and complementary treatments. If you decide to undergo treatment by a complementary practitioner, he or she will bill you directly.
(h) H.I.P may refer your child to Erin M. Woessner, DO for osteopathic evaluation and treatment. However, under no circumstances must you follow this recommendation. If you decide not to follow this suggestion, it will not alter the treatment that H.I.P provides. Dr. Woessner is board certified in neuromuscular medicine and osteopathic medicine and family medicine. All fees associated with services provided by Erin Woessner, DO, are subject to the Financial Agreement and Assignment of Insurance clause above and payable to Highlands Integrative Pediatrics, PC.

Signatures

I, the undersigned, have read and fully understand the above information, and I hereby give consent to undergo treatment at Highlands Integrative Pediatrics, PC.

_____ _____

Patient (if 18 years or older)/Parent or Legal Guardian Date