

ADOLESCENT & CHILD CARE SPECIALISTS, PC

210 MCNEEL LANE
NORTH PLATTE, NE 69101
(308) 534-9230

INTAKE FORM

DELL A. SHEPHERD, M.D.
KATHY S. LOPEZ, M.D.
VIJAY K. PRASAD, M.D.

(PLEASE FILL OUT COMPLETELY)

LIST ALL CHILDREN WITH THE SAME PARENT INFORMATION

TODAY'S DATE			
NAME	SEX	DATE OF BIRTH	SS#
NAME	SEX	DATE OF BIRTH	SS#
NAME	SEX	DATE OF BIRTH	SS#
NAME	SEX	DATE OF BIRTH	SS#
NAME	SEX	DATE OF BIRTH	SS#
NAME	SEX	DATE OF BIRTH	SS#
NAME	SEX	DATE OF BIRTH	SS#

MOTHER OR GUARDIAN INFORMATION

RELATION TO PATIENT		SOCIAL SECURITY #	
NAME		DATE OF BIRTH	
PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS	CITY	STATE	ZIP
HOME PHONE	EMPLOYER	UNEMPLOYED <small>(PLEASE CHECK BOX)</small>	
CELL PHONE	WORK PHONE		

FATHER OR GUARDIAN INFORMATION

RELATION TO PATIENT		SOCIAL SECURITY #	
NAME		DATE OF BIRTH	
PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS	CITY	STATE	ZIP
HOME PHONE	EMPLOYER	UNEMPLOYED <small>(PLEASE CHECK BOX)</small>	
CELL PHONE	WORK PHONE		

PERSON RESPONSIBLE FOR PATIENT ACCOUNT (NOT Medicaid, Insurance Company, Ex-Husband/Wife)

--	--

EMERGENCY CONTACT PERSON (NOT LIVING WITH YOU)

NAME		RELATIONSHIP	
PHONE	ADDRESS		
CITY	STATE	ZIP	

TURN PAGE OVER

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY

SUBSCRIBER'S NAME

RELATIONSHIP

SOCIAL SECURITY #

BIRTH DATE

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY

SUBSCRIBER'S NAME

RELATIONSHIP

SOCIAL SECURITY #

BIRTH DATE

AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and hereby give permission to the physician to treat in the event that a medical emergency arises and I am unable to personally consent to the treatment.

FINANCIAL AGREEMENT

I agree to pay all fees and charges for such treatment. I agree to pay for all charges for myself and members of my family shown by statements promptly, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. If insurance has not been collected within 60 days, I assume responsibility for payment.

I have received a copy of Adolescent and Child Care Specialists, P.C. Office Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined in the ACCS Office Financial Policy.

SIGNATURE _____

DATE _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION TO INSURANCE CARRIER

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been informed of the Notice of Privacy Practices for Personal Health Information (PHI). I understand that it is posted at the facility and that a paper copy of the Notice is available to me upon request.

SIGNATURE _____

DATE _____

A copy of this assignment is as valid as the original.