



HEALTHY KIDS PEDIATRICS  
 3196 S. MARYLAND PKWY., SUITE 400.  
 LAS VEGAS, NV 89109

PHONE: (702) 902-4060

Fax: (702) 904-4058

PATIENT INFORMATION: PLEASE PRINT (BLACK INK ONLY)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insureds Date Of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insureds Date Of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:**

I hereby authorize medical treatment for the above named patient and fully acknowledge that all office visits are on a cash basis and will be paid in full at the time of visit, unless otherwise contracted by my insurance. **I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to HEALTHY KIDS PEDIATRICS for any fees not covered by insurance.**

X \_\_\_\_\_ I understand that my insurance will be billed as a courtesy to me. I also understand that it is my responsibility to follow up with my insurance company 30 days from the date of service, to make sure they are processing my claims. Healthy Kids Pediatrics charges a 1.5% service charge per month for balances remaining unpaid after 45 days. Any claims not paid within 90 days will be my responsibility.

X \_\_\_\_\_ If I do not pay my copays or deductibles at the time when they are due or at the time of service, I understand that I will be responsible for an additional \$10.00 administrative fee for each event, collection fees are additional.

X \_\_\_\_\_ In the event of default on any payments due to HEALTHY KIDS PEDIATRICS., I agree to pay costs of collection, including attorney fees. I hereby authorize the filing of any insurance in force and the direct payment to HEALTHY KIDS PEDIATRICS of any amounts on my claim. I further authorize the office of HEALTHY KIDS PEDIATRICS and all pertinent medical records necessary to facilitate insurance billing or medical care and authorize the creditor or higher agent to make any employment or insurance verification and release of all information needed to process claims. I hereby authorize the office of HEALTHY KIDS PEDIATRICS, to Receive, Mail, Fax, or E-mail my records to another physician or medical facility in the course of my diagnosis and treatment.

X \_\_\_\_\_ I also understand that I will be charged for an unexcused no-show or cancellation within 24 hours of my appointment time. I will be charged \$25.00 for an unexcused no-show or cancellation within 24 hours of my appointment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgment of Privacy Practices:** I hereby acknowledge that I have received a copy of this Notice Of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_