Smita Parikh Mengers, MD FAAP & Wendy R. VanBronkhorst, MD FAAP

Welcome to Our Practice

Patient Information

First Name_____MI_____ Last Name_____

Date of Birth_____ Male_____ Female_____ Transgender_____ Other_____

Address_____

City_____ State_____ Zip Code_____

Siblings

Name_____DOB_____M___F___ Name_____DOB_____M___F___

Name_____DOB_____M___F___ Name_____DOB_____M___F___

Parent Information

Please Check: ___Mother ___Stepmother ___Legal Guardian ___ Foster Parent Please Check: ___Single ___Married DOB_____

First Name_____ MI_____ Last Name_____

Address_____City_____State_____Zip Code_____

Phone (Home) _____ (Cell)_____ (Work)_____

Preferred Contact Number_____ Can we leave detailed messages on this number? Including test results? Yes____ No____

Please Check: ___Father ___ Stepfather ___Legal Guardian Please Check: ___Single ___Married DOB_____

First Name_____ MI_____ Last Name_____

Address_____City_____State_____ Zip Code_____

Phone (Home) _____(Cell)_____ (Work)_____

Preferred Contact Number_____ Can we leave detailed messages on this number? Including test results? Yes____ No____

Do you agree to receiving text messages? Including appointment reminders, test results, important office information ? Yes___ No___

Insurance Information

****All information must be filled out completely****

Primary Insurance	**Secondary Insurance**
Subscriber Name_____	**Subscriber Name_____**
Home Address_____	**Home Address_____**
Relationship to Patient_____ DOB_____	**Relationship to Patient_____DOB_____**
Insurance Carrier_____	**Insurance Carrier_____**
Policy Number_____	**Policy Number_____**
Group Number_____	**Group Number_____**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

By initialing below, I indicate that I have received a copy of Dr. Smita Parikh Mengers, MD and Wendy R. VanBronkhorst, MD Notice of Privacy Practices.

_____Initials

PLEASE READ CAREFULLY PATIENT-DOCTOR AGREEMENT

Insurance Authorization and Assignment of Benefits

- I authorize and request that insurance payments be made directly to this office and any medical payments from the patient's insurance for services rendered.
- I understand and agree that, I am financially responsible for payment of all professional services given my behalf to myself or to my dependents by this office which are not covered by my insurance company including co-payments and deductibles and in the event that my insurance benefits are cancelled, my insurance carrier's merger or my insurance company's termination of existence.
- I understand that if insurance is suspended or terminated, any fees for services rendered to the patient will be immediately due and payable.

_____Initials

Payment Policy

- I acknowledge full financial responsibility for services rendered and I understand payments for services are due on the day of service.
- This includes co-payments and payments for medical forms ($10.00 fee).

_____Initials

- Any balance that is left unpaid for over two billing cycles is subject to a $10.00 late fee.
- This late fee will be applied to any unpaid amount.
- If a check has been written for payment and the check is returned for insufficient funds, there will be a $25.00 fee added to your current balance.
- I understand that I am responsible for any charges that remain unpaid for a filed insurance claim after 45 days and said bill with be due at that time.
- I understand that in the unfortunate event, procedures are required to collect an outstanding account balance; I will be responsible for the additional fees incurred in collecting the unpaid amount including collection agency, accrued fees at an APR of 18%, attorney's fees and/or court cost.

_____Initials

Please speak to us about any concerns you may have. By communicating how your experience was in our office, you enable us to provide you with the best care possible. Thank you!

By signing below, I indicated that I have read the above policies and agree to the applicable conditions, I consent treatment, financial responsibility and insurance authorization.

_____

Parent/ Legal Guardian Name

_____ _____

Parent/ Legal Guardian Signature Date

Smita Parikh Mengers, MD FAAP & Wendy R. VanBronkhorst, MD FAAP

Our Appointment Policy

Our office is dedicated to providing all our patients with the most thorough and comfortable pediatric care available. We know that efficient scheduling is an important part of the office experience. We appreciate your respect for our daily schedule which allows our staff to be on time for your children. **We will always respect your time.**

To enable us to provide efficient care we ask for your cooperation with the following guidelines:

We DO NOT accept walk-in appointments, please call and schedule your child's sick or well visit.

****Parents/Legal guardians MUST be present at any/all well check appointments. ****

1. **On Time Arrival:** Please arrive at, or just before, your appointment time.
2. **Late Arrival:** If you arrive late for your child's appointment, we reserve the right to reschedule the appointment. Late arrivals will cause a delay in seeing patients who are on time. If you find you are running late, we recommend you call our office to determine if we can hold your appointment. This will also count as a missed appointment.
3. **Rescheduling:** We require a **24 hour notice** for rescheduling any appointment. You must contact our office to do so.
4. **Cancelled/Missed Appointments:** If you do not notify our office with 24 hour notice, the following fees apply and will be added to your account:
   For missed appointments- **$45.00 per child**
   *****Reminder Calls:** Not getting a reminder call/text is not a reason to miss your appointment. This is a courtesy call only.

****This policy applies to all appointments at our office****

Should you no-show for 3 appointments, you may be discharged from the practice.

We feel these guidelines are reasonable in relation to the services we provide. We do understand that circumstances occur that will require consideration.

I understand that I am expected to follow this policy as a patient at this office.

(Parent) Print Name: _____

(Parent) Signature: _____

Date: _____

Smita Parikh Mengers, MD FAAP & Wendy R. Vanbronkhorst, MD FAAP

AUTHORIZATION FOR HEALTH CARE SERVICES

I give authorization to the following individuals listed below to make medical decisions for my child (ren) in my absence (i.e. grandparent, relative, neighbor, babysitter):

First and Last Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

These individuals are authorized to take any and all lawful acts, deeds, matters, and things in any way connected with my child's health care. Such authorization includes, but is not limited to, the giving, refusing, or withdrawing consent to provide professional services on behalf of my child (ren).

This authorization shall remain in full force and effect until one or both of us are available by telephone, in person or otherwise to make health care decisions for my child (ren).

_____

Print name of Parent/ Legal Guardian

_____ _____

Signature of Parent/ Legal Guardian Date