Sunflower Pediatrics, PC

12500 West 58th Ave, Ste 233
Arvada, CO 80002
720-536-5282

Patient Information

Patient information

Child's name: _____ Birth date:_____ M or F
Child's name: _____ _____ Birth date:_____ M or F
Child's name: _____ _____ Birth date:_____ M or F
Child's name: _____ _____ Birth date:_____ M or F

Parent Information

MOTHER'S INFORMATION

Mother's Name

Mother's SS #
DOB

Spouse's Name
If different from Father

Address
City, State, Zip

Home Phone Number

Cell Phone

Employer Name /Occupation

Work Phone Number

FATHER'S INFORMATION

Father's Name

Father's SS #
DOB

Spouse's Name
If different from Mother

Address
City, State Zip

Home Phone Number

Cell Phone

Employer Name /Occupation

Work Phone Number

Emergency Contact (not living in home)

Name: _____
Relationship: _____
Phone #: _____

HIPPA Consent

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

Signature:_____ Date _____

Treatment Consent and Disclosure

Our practice may use your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) to treat you. For example, we may ask you to have laboratory tests (ie: blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

Signature:_____ Date:_____

Financial Agreement and Assignment of Benefits

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 Sunflower 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 if provided. I also authorize the release of any medical information necessary to process the claim. Failure to comply with this financial policy may results in the following actions: dismissal from the practice and referral to a collection agency.

If you need to reschedule or cancel an appointment , please call our office at least 24 hours in advance to avoid a $30 cancellation fee. This fee can also be implemented for a no- show appointment as well.

Signature:_____ Date:_____

Vaccination Policy

We recommend the routine vaccine schedule recommended by the CDC and the American Academy of Pediatrics. Alternative vaccine schedules can be discussed with your provider. We strongly believe that a child's life is at risk if they are not immunized. It is your legal right to refuse vaccines, however we feel that your choice will prevent a productive relationship with your pediatrician. Sunflower Pediatrics, PC will not agree to begin a relationship with families who choose not to vaccinate their children with routine vaccines (ie: those required by schools).

Signature:_____ Date:_____