PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: _____ DATE OF BIRTH: _____

SEX: Female☐ Male☐ PATIENT'S SS #: _____

RACE: ☐White/Caucasian ☐Native American ☐Hawaiian Native/Pacific Islander ☐Black/African American ☐Asian

OTHER: _____

ETHNICITY: ☐Hispanic ☐Non-Hispanic

Preferred Language: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RESPONSIBLE PARTY (Guarantor): _____

Primary Insurance Holder name: _____

INSURANCE COMPANY: _____

ID NUMBER: _____

DOB Of Insured: _____RELATIONSHIP: ☐Mother ☐Father OTHER: _____

Secondary Insurance Holder name: _____

INSURANCE COMPANY: _____

ID NUMBER: _____

DOB Of Insured: _____RELATIONSHIP: ☐Mother ☐Father OTHER: _____

(In office use only: Insurance Verified by _____)

PARENT #1: _____ MOTHER☐ FATHER☐ GUARDIAN☐

Email: _____ Phone # _____

DOB: _____ SS#: _____

ADDRESS if different:_____

CITY: _____ STATE: _____ ZIP: _____

Place of Employment: _____Employment PHONE # _____

PARENT #2: _____ MOTHER☐ FATHER☐ GUARDIAN☐

Email: _____ Phone # _____

DOB: _____ SS#: _____

ADDRESS if different:_____

CITY: _____ STATE: _____ ZIP: _____

Place of Employment: _____Employment PHONE # _____

Who may we contact other than a Parent/Guardian, In case of Emergency:

_____ Phone #: _____

Relationship to Patient: _____

Siblings Also Seen in Our Office: _____

HOW DID YOU HEAR ABOUT US? _____

Thompson River Pediatrics – Consent to Treat, AI & HIPAA Agreement

I, the undersigned parent or legal guardian, hereby authorize the physicians, nurse practitioners, physician assistants, and clinical staff of Thompson River Pediatrics to provide medical evaluation, diagnosis, and treatment for the minor patient named above. This consent includes, but is not limited to:

- Routine and preventive care, including well-child examinations
- Diagnostic procedures, including laboratory tests, imaging, and screening assessments
- Treatment of acute and chronic illnesses and injuries
- Administration of medications as deemed medically appropriate
- Emergency first aid and stabilization measures

I understand that:
- The nature of any proposed treatment, its risks, benefits, and alternatives (including no treatment) will be explained to me before treatment is provided, and I will have the opportunity to ask questions.
- This consent remains in effect until revoked in writing by the undersigned.
- In the event of an emergency where I cannot be reached, I authorize Thompson River Pediatrics to provide necessary emergency care and treatment
- I have the right to refuse or withdraw consent for any treatment at any time.

Authorized Persons to Consent to Treatment in My Absence:
I authorize the following individuals to consent to medical treatment for my child if I am unavailable:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
I acknowledge that I have been offered a copy of the Thompson River Pediatrics Notice of Privacy Practices, which describes how my child's protected health information (PHI) may be used and disclosed, and my rights regarding that information under the Health Insurance Portability and Accountability Act (HIPAA).

I understand that Thompson River Pediatrics may use and disclose my child's PHI for the following purposes without additional authorization:

- Treatment: Sharing information among physicians, nurses, and clinical staff involved in my child's care, including referrals to specialists and coordination with other healthcare providers.

- Payment: Submitting claims and related information to health insurance plans, managed care organizations, or other third-party payers to obtain reimbursement for services provided.

- Healthcare Operations: Activities such as quality improvement, staff training, compliance audits, and business management necessary for the operation of the practice.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
A. Release to Insurance / Third-Party Payers

I authorize Thompson River Pediatrics to release my child's medical records, billing information, and any other protected health information necessary to process insurance claims, obtain pre-authorizations, and facilitate payment for services rendered. This includes release to:

- My child's health insurance plan(s)
- Managed care organizations
- Government payers (e.g., Medicaid, CHIP)
- Other third-party payers responsible for my child's healthcare costs

B. Release to Clinic Staff

I understand and consent that my child's medical information will be accessible to authorized Thompson River Pediatrics staff members — including physicians, nurse practitioners, physician assistants, nurses, medical assistants, front desk personnel, and billing staff — on a need-to-know basis for the purposes of treatment, care coordination, scheduling, and practice operations.

C. Additional Release Authorization (Optional)

I authorize Thompson River Pediatrics to release my child's medical information to the following individuals or entities:

Name	Relationship/ Purpose	Phone/Fax
_____	_____	_____
_____	_____	_____

CONSENT FOR ELECTRONIC COMMUNICATIONS
Thompson River Pediatrics offers electronic communication for appointment reminders, health information, test results, billing notices, and other practice communications. I understand that:

- Electronic communications (text messages and emails) are not guaranteed to be fully secure and may be subject to interception or unauthorized access.

- Thompson River Pediatrics will take reasonable steps to protect my information but cannot guarantee the security of electronic transmissions.
- I may opt out of electronic communications at any time by notifying the office in writing.
- Standard messaging and data rates may apply for text messages.
- Electronic communications are not intended for medical emergencies. In case of emergency, I should call 911 or go to the nearest emergency department.

I consent to receive electronic communications from Thompson River Pediatrics:

☐ Yes, I consent to electronic communications
☐ No, I do not consent to electronic communications

Preferred method of electronic communication (select one or both):

☐ Text Message — Mobile Number: (__) __-_____
☐ Email — Email Address: _____

CONSENT FOR USE OF ARTIFICIAL INTELLIGENCE (AI) DURING CARE

Thompson River Pediatrics may use artificial intelligence (AI)-enabled technologies to assist healthcare providers with clinical documentation, visit note generation, medical record organization, and other administrative or clinical support functions. These tools support—but do not replace—the independent medical judgment of your child's healthcare provider.

• AI tools may process information discussed during visits to assist with documentation and workflow.
• Your child's provider reviews and approves all documentation and remains responsible for all clinical decisions.
• AI technologies will be used in accordance with applicable HIPAA and Colorado privacy requirements and reasonable safeguards will be used to protect health information.
• You may ask questions about the practice's use of AI at any time.

Consent:

☐ Yes, I consent to the use of AI-assisted technology during my child's care.
☐ No, I do not consent to the use of AI-assisted technology during my child's care. I understand this decision will not affect my child's access to care.

SIGNATURES

By signing below, I confirm that:
- I have read and understand this Consent to Treat, HIPAA Agreement, and Communication Preferences form.
- I have had the opportunity to ask questions and have received satisfactory answers.
- I am the parent or legal guardian of the minor patient named above and have the legal authority to consent on their behalf.
- All information provided is accurate and complete to the best of my knowledge.
- I understand that this consent remains in effect until revoked in writing.

Patient Name: _____
Parent/Guardian/Guarantor Name: _____
Signature: _____
Date: _____

Employee Signature _____

FINANCIAL POLICY

Thank you for choosing Thompson River Pediatrics for your child's healthcare needs. This Financial Policy is intended to help families understand their financial responsibilities and our billing procedures. By receiving services from our practice, you agree to the following terms.

Insurance Information
As a courtesy to our patients, our office may attempt to verify insurance eligibility and benefits prior to your appointment. However, insurance verification is not a guarantee of coverage, payment, network participation, benefits, eligibility, deductible status, copayment amount, coinsurance amount, or any other aspect of your insurance plan.

It is the patient's sole responsibility to understand and verify the details of their insurance coverage, including but not limited to network participation, covered services, exclusions, benefit limitations, referral requirements, authorization requirements, deductibles, copayments, coinsurance, and out-of-pocket obligations.

Our office cannot guarantee that we are participating providers with every insurance product, network, or benefit plan offered by an insurance company. Patients are responsible for confirming that our providers and services are covered under their specific insurance plan prior to receiving treatment.

Patients are responsible for providing complete, accurate, and current insurance information at the time services are rendered. If insurance information is not provided, is inaccurate, is incomplete, or is not provided within the filing deadlines established by the insurance carrier, our office may be unable to submit claims to the insurance company. In such cases, the patient agrees to accept full financial responsibility for all charges incurred.

Most insurance companies impose strict deadlines for claim submission. If insurance information is provided after the insurance carrier's filing deadline has passed, our office will be unable to submit the claim, and the patient will be responsible for payment in full.

The patient understands and agrees that all professional services rendered by this office are ultimately the financial responsibility of the patient, regardless of insurance coverage, benefit determinations, network status, preauthorization decisions, claim denials, non-covered service determinations, medical necessity determinations, policy exclusions, coordination of benefits issues, or any other decision made by an insurance company or third-party payer.

If an insurance company denies payment, reduces payment, determines that services are non-covered, applies charges toward a deductible or coinsurance obligation, or otherwise fails to pay for services rendered, the patient agrees to remain financially responsible for any outstanding balance permitted by law and applicable payer contracts.

Patient Financial Responsibility
The parent, legal guardian, or guarantor who authorizes treatment is financially responsible for all charges incurred for the patient. Patient responsibility may include:

- Copayments
- Coinsurance
- Deductibles
- Non-covered services
- Services denied by insurance for reasons other than provider error

Payment of known patient responsibility amounts is due at the time of service. We reserve the right to refuse non-emergency services to patients that have outstanding balances. Balances that remain unpaid will result in dismissal from the practice for non-payment.

Self-Pay Patients
Patients without insurance coverage are responsible for payment at the time services are rendered unless prior arrangements have been approved by the practice. The practice reserves the right to bill a self-pay patient for any additional charges that were not collected at the time of service. (ie Lab work that was performed and not paid for at the appointment.)
Upon request, self-pay patients may receive information regarding anticipated charges before services are provided when feasible.

Payment Methods
We accept: Cash, Checks, Credit and debit cards, and HSA and FSA cards
A fee of $20 may be assessed for returned checks as permitted by law.

Statements and Outstanding Balances
Patient statements are issued for any balance remaining after insurance processing. Patient responsibility is determined by the patient's insurance plan, including deductibles, copayments, coinsurance, non-covered services, and denied charges. Questions regarding insurance processing, benefit determinations, or patient responsibility should be directed to the patient's insurance carrier.

The practice makes every effort to provide accurate and timely statements; however, we cannot guarantee delivery due to circumstances beyond our control. Failure to receive a statement does not relieve the patient of responsibility for any balance owed or any applicable late fees or collection activity.

Payment is due within 30 days of the statement date.
Patients may request:

- An itemized statement
- An explanation of charges
- Assistance regarding billing questions

Families experiencing financial hardship are encouraged to contact our office to discuss payment arrangements before accounts become delinquent.

Collections
If an account remains unpaid despite reasonable collection efforts, the account may be referred for additional collection activity as permitted by applicable federal and Colorado law.

The practice reserves the right to refuse non-emergency services to patients with outstanding balances. Failure to resolve unpaid balances may result in dismissal from the practice in accordance with applicable laws, regulations, and practice policies.

Prior to any collection action, our practice will comply with all applicable notice, billing, and patient communication requirements required by Colorado law.
Nothing in this policy waives any rights or protections provided to patients under Colorado law.

Health First Colorado (Medicaid) Patients
For patients covered solely by Health First Colorado (Colorado Medicaid), our practice will comply with all applicable state and federal regulations regarding patient billing.

Patients are required to disclose any additional health insurance coverage. Any insurance coverage other than Medicaid is generally primary to Medicaid, and claims must be billed in the appropriate order. Failure to provide accurate and complete insurance information may result in delays in claim processing and may affect coverage determinations.

The practice reserves the right to refuse non-emergency services to any patient who fails to cooperate in resolving insurance coverage, eligibility, coordination of benefits, or other insurance-related issues necessary for the proper billing and processing of claims.

Divorced or Separated Parents
The parent or legal guardian who presents the child for treatment and/or has signed as guarantor on the account is responsible for payment.
Any allocation of healthcare expenses between parents pursuant to a divorce decree, parenting plan, or court order is a matter between the parents and does not alter the financial responsibility owed to this practice.

The parent or legal guardian who presents with the child for services is responsible for payment of all applicable copayments, deductibles, coinsurance amounts, and outstanding balances at the time of service. Any balance due on the account must be paid in full prior to future non-emergency visits unless other arrangements have been approved by the practice.

Acknowledgment
I have read, understand, and agree to this Financial Policy. I understand that I am financially responsible for charges not paid by insurance and agree to comply with the terms described above.

Patient Name: _____ Employee Signature_____
Parent/Guardian/Guarantor Name: _____
Signature: _____
Date: _____



No-Show Policy

When we schedule an appointment time for your child we are holding that 20 minutes for you. We schedule appointments every 20 minutes, so if you are more than 10 minutes late for your appointment you have already missed half of your saved appointment time. Our providers have very full schedules and if you miss your time you cannot expect us to squeeze you in, you will be asked to reschedule. Please take into account that our providers are scheduling about 2-4 weeks out for Well Checks and if you miss your appointment we won't have one available for you the following day or even the same week, so please plan accordingly. If you don't show up we could have given that appointment time to another patient that needed to be seen that day. It is very important to us to stay on schedule for our patients. We know that your time as parents is very valuable, as is our providers time. We want to make sure that every patient gets the best quality care at every appointment. Please keep in mind that we are doing everything in our power to make sure that you are seen on time and in a timely manner. There are times when unforeseen Emergencies occur that require our immediate attention. We do our best to take care of those and get back on schedule as quickly as possible. We ask that you respect this and help us by being on time or early to every appointment.

If you No-Show a total of 3 confirmed appointments per child/family, you will be dismissed from our practice and you will need to find a new primary care provider. If you cancel within 4 hours of your appointment it will be considered a No-Show. Once dismissed from our practice you will no longer be able to take advantage of our convenient Walk-In hours.

We understand that emergencies come up and that certain circumstances may keep you from being able to make an appointment. We are understanding of those times. This is solely for the purpose of those families that take advantage of our generosity and continue to abuse it.

Thank you for your understanding.

Patient Name: _____

Parent Signature: _____

Date: _____