Hometown Pediatrics, LLC

New Patient Intake Packet

Parent / Legal Guardian #1

Full legal name	DOB	SS#	Relationship to child
Address			
Phone			
Email			
Employer			

Parent / Legal Guardian #2 (if applicable)

Full legal name	DOB	SS#	Relationship to child
Address			
Phone			
Email			
Employer			

Financially Responsible Party (billing)

If different from the parent/guardian above, designate one person for billing purposes. This does not change custody rights.

Name	
Relationship to child	

Insurance Information (bring cards to each visit)

Primary Insurance

Insurance company name	
Subscriber (policy holder) name	
Relationship of subscriber to child	
Member ID	
Group #	
Insurance phone (from card)	

Secondary Insurance (if applicable)

Insurance company name	
Subscriber (policy holder) name	
Relationship of subscriber to child	
Member ID	
Group #	
Insurance phone (from card)	

Children to be Registered (up to 5)

Child full legal name	DOB	Preferred name (optional)

Emergency Contact (other than parent/guardian)

Name	Relationship	Phone

Consents & Acknowledgments

Please initial each item and sign at the bottom.

____ I certify that I am the parent or legal guardian of the minor child(ren) listed in this packet.

____ Consent for Treatment: I consent to medical evaluation, diagnostic testing, immunizations, and treatment deemed medically appropriate by the providers of Hometown Pediatrics, LLC, in accordance with Ohio law.

____ HIPAA: I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

____ Electronic Prescribing: I authorize electronic prescribing and medication history/pharmacy benefit exchange as permitted by law. I understand I may revoke this authorization in writing.

____ Communication: I authorize contact by phone, text, email, and patient portal for appointment reminders, clinical information, billing matters, and practice communications. Standard messaging rates may apply.

Parent/Legal Guardian Signature: _____

Printed name: _____

Date: _____

Office, Administrative & Financial Policies

Copayments and balances due at time of service: Copayments, deductibles, and coinsurance are due at the time of service.

Insurance card required: A valid insurance card must be presented at each visit. Failure to provide current insurance information may result in self-pay billing.

Forms: Forms completed during well-child visits are provided at no charge. Forms requested outside of visits are $10 per form with up to 5 business days for completion. Rush forms may be completed for an additional $5 fee when available. FMLA and extended forms require a $25 administrative fee and 7-10 business days for completion.

No-show / late cancellation: Appointments not cancelled at least 24 hours in advance or missed appointments are subject to a $50 fee. This fee is not billable to insurance.

Unpaid balances: Unpaid balances remain the responsibility of the parent or legal guardian. Hometown Pediatrics reserves the right to reschedule non-urgent appointments or deny future appointments until outstanding balances are resolved.

Patient portal billing: Portal messages requiring medical decision-making or extended electronic communication may result in a charge and may or may not be covered by insurance.

☐ I have read, understand, and agree to the above office, administrative, and financial policies.

Parent/Legal Guardian Signature: _____

Date: _____

Divorced or Separated Parents

• Hometown Pediatrics does not mediate custody disputes or interpret court orders.

• The parent or guardian presenting the child for care is responsible for payment at the time of service unless otherwise arranged in writing.

• Court documentation must be provided for any limitations on parental access to medical information or decision-making.

• In the absence of court documentation, both parents will have equal access to medical information as permitted by law.

• Charges will not be divided or billed separately between parents.

Consent by Proxy – Authorized Adults

List adults who may bring your child to appointments and consent to routine medical evaluation and treatment when you are not present. This authorization does not transfer legal custody.

Authorized adult full name	Relationship	Phone

Parent/Legal Guardian Signature: _____

Date: _____

Authorization for Release of Health Information (Records Request)

Complete this form if you would like us to request records from another office/facility. This authorization expires in 1 year unless otherwise specified.

Patient name	
DOB	
Facility/Provider releasing records (FROM)	
Phone / Fax	

Records requested (check all that apply)

☐ Complete medical record

☐ Immunization record and growth chart

☐ Recent office notes / problem list

☐ Other: _____

Purpose of disclosure / reason for request

_____

Records RELEASED TO

Hometown Pediatrics, LLC

152 W 2nd St, Delphos, OH 45833

Phone: 567-765-1111 Fax: 567-765-1110

Authorization expiration (optional)	
Relationship to patient	

Signature: _____

Date: _____

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