Drs. Vigneri and Knudson-Johnson Date _____

732 W Collins Dr.

Casper, WY 82601

307-333-6940

If accepted into the practice, you will be notified within 3-4 weeks of receival of the application

Child(ren)'s Name(s):

Last_____First_____Middle_____

DOB: ___/____/____Gender: M___F___Significant Medical Problems: _____

Last_____First_____Middle_____

DOB: ___/____/____Gender: M___F___Significant Medical Problems: _____

Last_____First_____Middle_____

DOB: ___/____/____Gender: M___F___Significant Medical Problems: _____

Has your child(ren) seen any other physicians in Casper: _____

Are your children's immunizations current? _____Can you provide a copy_____

Note: All immunizations done in Wyoming are posted online on the Wyoming Immunization Registry

Parent/Guardian Information:

Name: _____Relationship to patient_____

DOB: ___/____/____ Phone: _____

Address: _____

Employer: _____ Phone: _____

Parent/Guardian Information:

Name: _____Relationship to patient_____

DOB: ___/____/____ Phone: _____

Address: _____

Employer: _____ Phone: _____

Emergency Contact (not residing with you) _____

Relationship to patient: _____Phone: _____

Insurance Information: Please bring a current insurance card to your first visit and any time it changes

Primary Insurance Carrier_____

Policy Holder: _____Policy #_____Group #_____

Secondary Insurance Carrier_____

Policy Holder: _____Policy #_____Group #_____

Medicaid: Medicaid care must be presented at each visit. If eligibility cannot be determined, payment is due at the time of visit. If eligibility can be proven later, patient will be refunded.

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment promptly upon receipt unless credit arrangements or payment plans are agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of billing date.

All returned checks will be charged a $35 fee. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to the person listed above, I agree to pay reasonable service charges, attorney's feeds or other such costs as the court determines proper.

Your insurance is a contract between you and the insurance company; we are not a party to that contract. It is agreed that your payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereof. (A copy of this assignment is valid as original.) We emphasize that as a medical provider, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend, all charges are your responsibility from the date services are rendered.

Your (PHI) Public Health Information will remain strictly confidential in compliance with federal and state laws concerning (HIPPA) Health Insurance Portability and Accountability.

Drs. Vigneri and Knudson are in private practice and share call coverage. After hours we all use the pediatric phone triage service out of Denver Children's Hospital. INT_____

Drs. Vigneri and Knudson believe in safety and efficacy of Immunizations for children. If you do not wish to immunize your child(ren), we would not be suitable for your needs. Drs. Vigneri and Knudson do not do alternative immunization schedules. INT_____

Drs. Vigneri and Knudson believe that all children should see the same pediatrician and so if 1 child of the family is transferred or sees another provider we will assume that the entire family is transferred. Different providers practice differently and it does effect the patient/parent and physician relationships when different providers are seeing different children in the same family. INT_____

Drs. Vigneri and Knudson, in agreement with the American Academy of Pediatrics standards on well child appointments, would like to see your child yearly when healthy for a physical; 2 years without being seen for a physical result in your child(ren)'s charts to be inactivated, and we will believe that Dr. Vigneri or Knudson is no longer your child(ren)'s physician. INT_____

The office will submit insurance claims; if you do not have insurance coverage or your insurance does not cover medical services rendered then payment is due at the time of the visit. INT_____

Cancellation of appointments requires 24-hour notice or a $25 no show fee will be applied to your account. INT_____

Prescription refills require 24-hour advance notice. INT_____

Notice: Do not sign this agreement before you read and agree to the conditions set to a copy of the agreement. Keep it to protect your legal rights.

Agreement: the above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor (Dr. Melissa Knudson-Johnson/Dr. Robert Vigneri) or her collection agency to make credit investigation including Employment verification.

Signature:_____

Please fill out form completely, sign and return to the office.