

FAMILY INFORMATION

2026

Statement of Nondiscrimination

Centennial Valley Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Preferred Language: English SPA OTH

CHILDREN'S NAMES & BIRTH DATES

1				
Last Name	First	Middle	Birth Date	
Gender	Race	Ethnicity	Religion	
2				
Last Name	First	Middle	Birth Date	
Gender	Race	Ethnicity	Religion	
3				
Last Name	First	Middle	Birth Date	
Gender	Race	Ethnicity	Religion	
4				
Last Name	First	Middle	Birth Date	
Gender	Race	Ethnicity	Religion	
5				
Last Name	First	Middle	Birth Date	
Gender	Race	Ethnicity	Religion	

GUARDIAN/PERSON RESPONSIBLE FOR PAYMENT

Last Name	First	MI	Relationship to Patient					
Birth Date	Social Security Number	<u>Marital Status:</u>		married	divorced	single	widowed	partnered
Home Address	City	County	State	Zip +4				
Which children live @ this address?								
Home Phone Number	Cell Phone Number	Work Phone Number	E-Mail Address					
Employer	Occupation							

OTHER GUARDIAN'S INFORMATION

Last Name	First	MI	Relationship to Patient					
Birth Date	Social Security Number	<u>Marital Status:</u>		married	divorced	single	widowed	partnered
Home Address	City	County	State	Zip +4				
Which children live @ this address?								
Home Phone Number	Cell Phone Number	Work Phone Number	E-Mail Address					
Employer	Occupation							

PLEASE COMPLETE THE BACK OF THIS FORM

MEDICAL INSURANCE INFORMATION

Insurance Company Name _____

Insurance Billing Address _____

Member ID Number _____

Group Number _____

Effective Date _____

Subscriber (parent) name _____

"I authorize payment of medical benefits to Centennial Valley Pediatrics for professional services rendered and the release of any medical information necessary to process insurance claims. I also authorize Centennial Valley Pediatrics to give my child/children reasonable & proper medical care by today's standards."

Signature of Patient/Legal Guardian _____

Date _____

INSURANCE COVERAGE WAIVER

"I understand that my eligibility for coverage by _____ (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from Centennial Valley Pediatrics. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided."

Signature of Patient/Legal Guardian _____

Date _____

PRIVACY PRACTICES ACKNOWLEDGMENT

"I have been provided the opportunity to review the Notice of Privacy Practices."

Print your name _____

Signature _____

Date _____

OFFICE POLICY

Payment in full is due at the time of service unless other arrangements have been made in writing through this office. We are not responsible for filing or collecting your insurance claims unless you are covered by one of our contracted insurances. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pending claims. All proceeds of insurance are assigned to this office when applicable, but without this office assuming responsibility for the collection of the claim. Copayments are due at the time of service.

"I agree to pay, within a timely period, all deductibles, copayments, after hours urgent care or no-show fees assessed to my account. A monthly rebilling fee is assessed after 30 days. I agree that if it becomes necessary to forward my account to a collection agency, that, in addition to the amount owed, I may also be responsible for costs of collection, including attorney fees."

I certify that I have read, understand and will comply with the above information."

Signature of Guardian _____

Date _____

ACKNOWLEDGMENT OF EMERGENCY CARE PLAN

"I delegate Centennial Valley Pediatrics, or the medical provider(s) they may delegate, to provide any and all medical or surgical care which these children may require in the event that I am unavailable. This will apply only to situations where the delay of that care until such time as I might reasonably be expected to be available would be detrimental to the children. This includes my permission for the children to be admitted to a hospital and the performance of surgery and anesthesia as deemed advisable by the above-mentioned physicians or their delegates."

I hereby authorize Centennial Valley Pediatrics to administer such medications and perform such diagnostic or therapeutic procedures as may be necessary for the prudent medical care of my children."

Signature of Guardian _____

Date _____

EMERGENCY CONTACT (other than parent)

Last Name _____

First _____

Relationship to Patient _____

Home Address _____

City _____

State _____

Zip _____

Home Phone Number _____

Cell Phone Number _____

Work Phone Number _____

******Who may we thank for referring you to us?******

Name _____

Address _____

Street _____

City _____

State _____

Zip _____