

Preferred Pediatrics

Anne T. Boudreaux, M.D.

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Hayley M. Chatagnier, FNP-C

Patient Information

Date: _____

Minor/Child:

Last Name: _____ First Name: _____ Middle: _____

Primary Phone: _____ Sex: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Race: _____ Ethnicity (Check one): Hispanic or Latino: yes ___ no ___

Siblings: _____

Responsible Parties:

Father/Guardian's Name: _____ Date of Birth: _____

Mailing Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SSN: _____ Employer: _____ Work Phone: _____

Email Address: _____ Genetic Father: Yes _____ No _____

Mother/Guardian's Name: _____ Date of Birth: _____

Mailing Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SSN: _____ Employer: _____ Work Phone: _____

Email Address: _____ Genetic Mother: Yes _____ No _____

Insurance Information

Name of Primary Policy Holder: _____ Date of Birth: _____

Mailing Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SSN: _____ Employer: _____ Work Phone: _____

Insurance Company: _____ Policy #: _____ Group #: _____

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

Emergency Contact (other than parent/guardian): _____

Relationship: _____ Daytime Phone: _____ Cell Phone: _____

How did you hear about our practice? _____

Appointment reminders: Text ___ Phone ___ (Home or Cell) Contact: Mom ___ Dad ___

PATIENT NAME _____ DOB _____

POLICIES OF PREFERRED PEDIATRICS LLC

COMMERICAL HEALTH INSURANCE

As a courtesy to me, the physicians at Preferred Pediatrics LLC will file claims for healthcare services provided on my behalf directly to my health insurance carrier as long as my account remains in good standing. I hereby assign directly to the physicians any and all health insurance benefits to which I am entitled and which are payable to me for any services rendered.

NO INSURANCE OR LIMITED COVERAGE

If I have no insurance or limited coverage for the charges incurred on this account, I agree to pay the full balance of such charges at the time of serviced or in accordance with payment terms agreed upon by Preferred Pediatrics LLC. I am responsible (1) for determining whether the services of Preferred Pediatrics LLC are covered by my insurance contract, (2) for verifying that my correct insurance and contact information is on file, and (3) for promptly notifying Preferred Pediatrics of any changes. Well visits, immunizations, and any other charges denied by my insurance carrier are my financial responsibility. I understand that all available courses of action will be utilized by Preferred Pediatrics LLC to secure payment on delinquent accounts, including but not limited to professional collection services and credit bureau reporting. If applicable, professional collection & search fees will be charges to my account.

RELEASE OF INFORMATION

I authorize Preferred Pediatrics LLC to release any and all medical information, including but not limited to a photocopy of patient's medical records, (1) which may be requested by my insurance company to process insurance claims and remit payment of health insurance benefits or (2) which may be necessary in coordinating medical care with specialists or other healthcare professionals in the course of treatment.

Further, I authorize the use of my signature below on all insurance submissions made by Preferred Pediatrics LLC for healthcare services provided.

SCHEDULING

I understand that well-visit appointments must be made in advance. I will arrive 5 to 10 minutes earlier than my appointment time and call if I anticipate being late. I will call 24 hours in advance if I need to cancel well-visits or rechecks and will give at least two hours notice if I must cancel a sick visit. I understand that visits are by appointment only and will call before leaving home if I am having an emergency so the physician and staff can prepare for my arrival. I will be responsible for any after-hours, walk-in, or urgent care fees not covered by my health plan.

NSF CHARGE

I agree to pay a \$25.00 charge on all checks returned for "Non-Sufficient Funds."

I have read and understand the above policies. I agree that such policies may be changed from time to time at the discretions of Preferred Pediatrics LLC, and I will comply to any such changes for as long as I have an account here. My signature acknowledges my full responsibility for any charges to this account regardless of my marital status, custody arrangements, or whether or not I am the legal guardian for the minor patient named above. My signature implies my authority to seek medical care for this patient, and I expressly give the physicians and staff of Preferred Pediatrics LLC permission to provide medical treatment any time the patient is presented for such and this account may be charged accordingly.

Signature of Responsible Party

Date

Preferred Pediatrics

I, _____,
parent/guardian of _____,
D.O.B. _____, am giving the following individuals permission
to bring _____ to the doctor for medical
treatment. They also have my permission to sign for any injections or
immunizations.

- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____
- _____ (Relationship) _____ (phone#) _____

Parent/Guardian Signature

Date

PREFERRED PEDIATRICS, L.L.C.

ACKNOWLEDGMENT

I, _____, (print name) have been given a copy of
the Notice of Privacy Practices of **PREFERRED PEDICATRICS, L.L.C**

SIGNATURE

DATE



*Anne T. Boudreaux, M.D.
Catherine S. Fangue, FNP-C
Hayley M. Chatagnier, FNP-C
BOARD CERTIFIED IN PEDIATRICS*

*142 Rue Marguerite; Thibodaux, LA 70301
985-449-PLAY (7529)
Fax: 985-449-7518*

Welcome to Preferred Pediatrics LLC, Pediatrics with a Mother's Touch.

We're very pleased that you have entrusted our physicians to care for your little one(s). We offer routine wellness exams, as well as caring for your child when he or she is ill. Since many insurance contracts vary in coverage, we've developed this checklist to help you understand ahead of time what services your insurance contract does not cover. Please call you insurance company and check if each of the following is covered by your policy:

_____ Visits for well-baby care

_____ Immunizations

Fees for services not covered by your insurance contract will become your responsibility. Wellness care is very important in documenting and monitoring the growth and development of your child. If your insurance coverage does not include wellness care, it is still in the best interest of your child to receive routine exams and preventative care. Our friendly billing department staff is always ready to assist you with payment plans should you find that your child's well visits will be your financial responsibility.

Please return this checklist to us at your next appointment.

Thank you!

Patient's Name _____

Patient's Date of Birth _____

Name of Insurance Company _____

Signature _____

Date Coverage Checked _____