Columbia Basin PEDIATRICS

"Always There with Nurturing Care"

Ekta Khurana, MD, & Michelle Crawford, ARNP

FAMILY INFORMATION

Please list each of your children that are seen as patients:

Last Name	First Name	M.I.	DOB	Sex: (M/F)	Patient's Cell Phone # (if over the age of 13)
1.					
2.					
3.					
4.					
5.					

PATIENT (S) INFORMATION

How did you hear about us (circle one and fill in blank):

☐ Phone Book ☐ Insurance Co. ☐ Parent of CBP Patient: _____ ☐ Friend/Other: _____

Who has legal custody? ☐ Mother ☐ Father ☐ Both ☐ Other_____

***Preference phone number for calls from office:** _____ **Email address:** _____

I authorize Dr Khurana and/or Michelle Crawford, ARNP to leave messages on answering machines/voicemails? ☐ Yes ☐ No Initial: _____

Mother/Guardian's Name:_____ DOB:_____ Home #:_____Cell#_____

Address:_____City:_____State:_____Zip:_____

Employer:_____Position:_____ SSN:_____ Work No.: _____

Father/Guardian's Name:_____ DOB:_____ Home No.:_____ Cell No.: _____

Address:_____City:_____State:_____Zip_____

Employer:_____Position:_____SSN:_____Work No.: _____

INSURANCE CARDHOLDER/GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Name:_____Birthdate:_____SSN:_____

Address:_____City:_____State:_____Zip_____

Phone No.:_____ Work No:_____Relationship To Patient:_____Employer:_____

EMERGENCY INFORMATION

Name of Person **NOT** Living with You:_____

Relationship To Patient:_____ Phone#:_____

MISCELLANEOUS

Race: ☐ American Indian and Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and Pacific Islander ☐ White ☐ Other_____

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic or Latino/Spanish ☐ Latin American/ Latin/Latino ☐ Mexican ☐ Not Hispanic or Latino ☐ Puerto Rican ☐ Spaniard ☐ Other_____

Language Preference: ☐ English ☐ Spanish ☐ Other_____ Barriers of Communication: ☐ Vision ☐ Hearing ☐ None

INSURANCE INFORMATION-CARD(S) ATTACHED

My child is covered by: ☐ Both parents' insurance ☐ Mother's Insurance ☐ Father's Insurance ☐ Molina ☐ DSHS

Child/Children's name:_____ Insurance Co-pay$:_____

Primary Ins:_____ Insured's ID:_____ Group No.:_____

Secondary Ins:_____ Insured's ID:_____ Group No.:_____

I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I assign medical and/or major medical insurance benefits to Dr. Ekta Khurana. I authorize Dr. Khurana/Columbia Basin Pediatrics to release all information necessary to secure payment and to file in my behalf any complaints necessary to the Washington Insurance Commissioner. I understand that a no show at the first visit will result in a dismissal for the entire family and 3 no shows for family within 1 year time frame will result in dismissal of the entire family. **I understand that a $25.00 administrative fee will be assessed for "No-Show" appointments and NSF checks**.

SIGNED:_____ DATE:_____

WITNESS:_____ DATE:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEGDEMENT

Columbia Basin Pediatrics has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time. For a current copy of our Notice of Privacy Practices you may visit the check in station at our office, visit our website www.columbiapeds.com or you may contact **Laura Ramirez** (509)946-7332.

By my signature below, I agree that I have received the Notice of Privacy Practices of Columbia Basin Pediatrics

Printed name of patient Patient DOB

Printed name of patient Patient DOB

Printed name of patient Patient DOB

Printed name of patient Patient DOB

Printed name of patient Patient DOB

Patient or legally authorized individual's signature Date Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

For Office Use Only

Office staff complete below:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons:

_____