DATE_____

Please select your Primary Care Provider (PCP)

☐ Kimberly Grandinetti, MD, FAAP

☐ Kim Resleff, ARNP

☐ Jennifer Kalisvaart, MD, FAAP

SPOKANE pediatrics

Kimberly Grandinetti, MD, FAAP
Kim Resleff, ARNP
Jennifer Kalisvaart, MD, FAAP

PATIENT INFORMATION

PATIENT NAME:_____
FIRST MI LAST NICKNAME

BIRTH DATE:_____**SEX**_____

Patient 13 & over Contact Information: Cell Phone: _____**E-MAIL:** _____

RACE:
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ ASIAN
☐ BLACK/AFRICAN AMERICAN
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
☐ WHITE
☐ PREFER NOT TO ANSWER

ETHNICTY:
☐ HISPANIC/LATINO
☐ NOT HISPANIC/LATINO
☐ PREFER NOT TO ANSWER

PREFERRED LANGUAGE:
☐ ENGLISH
☐ OTHER: _____
☐ PREFER NOT TO ANSWER

LIST ANY ADDITIONAL FAMILY MEMBERS ON NEXT PAGE.

PARENT/GUARDIAN INFORMATION:

PARENT 1:_____ PARENT 2:_____

RELATION TO CHILD:_____ RELATION TO CHILD:_____

LAST 4 DIGITS OF S.S. #:_____ LAST 4 DIGITS OF S.S. #:_____

BIRTH DATE:_____ BIRTH DATE:_____

ADDRESS:_____ ADDRESS:_____

CITY:_____ST:_____ZIP CODE:_____ CITY:_____ST:_____ZIP CODE:_____

PRIMARY PHONE:_____ PRIMARY PHONE:_____

EMPLOYER:_____ EMPLOYER:_____

WORK PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE: _____

Please have insurance card ready at check in so that we can scan it. Thank you.

In case of emergency:_____ Relationship:_____

Phone Number: _____

Name:_____DOB_____SEX:_____

13 and over contact information Cell Phone: _____E-MAIL: _____

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☐ OTHER: _____
☐ PREFER NOT TO ANSWER

If you are registering more than 4 children, please ask the front desk for an additional form.

Kimberly Grandinetti, MD, FAAP
Kimberly Resleff, ARNP
Jennifer Kalisvaart, MD, FAAP

Payment Policy
HIPAA Acknowledgement

PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR PAYMENT ARRANGEMENTS ARE MADE WITH OUR BILLING DEPARTMENT. Payment may be made by cash, check or credit card. On accounts which have established payment arrangements, the payment is due upon receipt of the monthly statement. In lieu of payment at the time of service we can bill the following insurers or insurance plans directly:

Premera Blue Cross (Heritage/Foundation, PPO, LifeWise)
First Choice Health Plan
WA Medicaid (DSHS Apple Health)
Cigna Healthcare
Kaiser Permanente
Molina Apple Health
Aetna
United Healthcare
Blue Shield (Blue Card) Plans
Asuris

It is up to you to provide us with all information necessary to bill your insurance company. We do not guarantee payment. You will be responsible for payment of all services not covered by your insurance company. It is your responsibility to follow up with your insurance to ensure payment is made. Known deductibles not yet satisfied are also due at time of service.

DELINQUENT ACCOUNTS: all accounts are due and payable within 30 days of services rendered. A **$25.00** returned check fee applied to any check returned by the bank. Unless a payment schedule has been arranged with the billing department, accounts left unpaid after 120 days will be turned over to an agency for collection follow-up and may result in dismissal from our practice of all children for whom you are the guarantor.

MEDICAID WAIVER: I ____ do ____ do not (**check one**) have Medicaid (DSHS) insurance coverage (either primary or secondary). If I do, I understand that if my Medicaid plan does not cover certain services provided, I am responsible for any balance due.

ACKNOWLEDGEMENT: I have read the above policy statement and understand that regardless of any insurance coverage I may have for my child(ren), I am responsible for payment of my account in a timely manner. I agree that in the event that costs and/or fees are incurred in connection with the collection of my account, I will pay all such cost and fees, including but not limited to collection costs, attorney fees and all court costs.

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby authorize payment by my insurance company directly to Spokane Pediatrics for those charges as described on the billing statement.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Spokane Pediatrics to release my insurance company any and all information they may require concerning patient care.

HIPAA Acknowledgement
I have received the Notice of Privacy Practice, and I have been provided an opportunity to review it.

I am the guarantor for the following individuals (and for whom I give Spokane Pediatrics permission to treat): (Please Print)

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Name:_____ DOB_____

Guarantor's Signature:_____ **Date**_____

Kimberly Grandinetti, MD, FAAP
Kimberly Resleff, ARNP
Jennifer Kalisvaart, MD, FAAP

APPOINTMENT REMINDER/PATIENT COMMUNICATION

By providing your contact information below, you are granting permission to be contacted via those communication channels for appointment reminders, reminders to schedule your next appointment and important announcements about our practice.

Parent 1 Cell Phone _____

Parent 2 Cell Phone _____

Home Phone _____

Email_____

☐ YES, I WOULD LIKE ACCESS TO PATIENT PORTAL FOR MY CHILDREN UNDER 13 YEARS OF AGE USING THE EMAIL I HAVE PROVIDED ABOVE OR: _____

Preferred method of contact for appointment confirmation/important announcements (**Only mark one**):
☐ TEXT ☐ CALL ☐ EMAIL PRIMARY CONTACT NAME:_____

Please list all patients for which this information is applicable:

1) _____DOB_____

2) _____DOB_____

3) _____DOB_____

4) _____DOB_____

5) _____DOB_____

6) _____DOB_____

I hereby grant Spokane Pediatrics permission to contact me via an automated phone/text/email system. I authorize Spokane Pediatrics to leave a message on this device.

Signature _____Date_____

Late/No-Show Policy:

If you arrive later than **15** minutes after your scheduled appointment time, you may be asked to reschedule or be seen as a walk-in if there is a provider available.

If you are unable to make your appointment, please call and reschedule so that other patients can be accommodated. Once you have accrued three no shows you may be asked to find a new primary care provider.

HIPAA Acknowledgement:

I have received the Notice of Privacy Practice, and I have been provided an opportunity to review it.

Policy Regarding "Well" Child Check-Ups

Well Child Check-Ups/Physicals will be billed as such to your insurance plan. Insurance companies may also refer to this as **PREVENTATIVE CARE** or **ROUTINE EXAM**.

Due to coding laws, we **MUST bill your WELL CHILD CHECK-UP** with a Preventative Care code. If, during your visit you have ADDITIONAL CONCERNS or PROBLEMS that are not classified as "preventative" and require a separate diagnosis and/or other treatment, this would then be considered separate from your preventative care and may incur additional office or lab charges. All applicable charges will be billed to your insurance company. If you would like to keep these visits separate, we would be happy to schedule another appointment for a different date.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate as "patient responsibility."

Your child's Well Exam is important whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about your family's coverage. There are many plans and your benefits can change often. We will be happy to answer any questions that we can. However, we will not directly know the provisions of your specific plan.

NOTE: Certain tests we order as part of your **Well Child Check-Up** may or may not be covered by your insurance. This includes, but is not limited to, blood work, lab tests and x-rays. If your insurance uses a particular lab, please make the nursing staff aware of this once in the exam room.

We appreciate your understanding and cooperation.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility."

_____Date_____

Patient/Guardian Signature