Child & Teen Medical Center
Love…Kindness…Excellence

Child & Teen Medical Center
Blaine & Fridley locations
763-333-7733 phone/763-333-7711 fax

CTMC-Patient Demographic Form

Patient Information:

Last Name (Legal):	First Name (Legal):	Full Middle Name:	Date of Birth (DOB): Month: Day: Year:
Gender:	Does Child live with both parents:	If not, who is the legal guardian:	***Please submit any judgements, decrees and/or birth certificate if there are any discrepancies in legal guardianship of the child***

RACE : White /American Indian/Alaskan Native /Asian/Black/African American/Hispanic/Latino/Native Hawaiian/Other Pacific Islander/Chose not to disclose /Unknown

(may choose more than 1)

ETHNICITY/COUNTRY OF ORIGIN: United States/Iran/Iraq/Laos/Lebanon/Mexico/Russia/Serbia/Somalia/Declined/
Other:_____

PRIMARY LANGUAGE: English/Arabic/Hmong/Laotian/Russian/Sign Language/Somali /Spanish/Thai/Urdu/Chose not to disclose/Other:_____

Does child/parent require an interpreter: **Agency/interpreter used:**

Patient Address:	Apt/Unit	City/State	Zip Code: County: School District:
Primary Contact Number: # _____ Who's phone is this?_____	Type of phone #	* Primary e-mail address for patient portal access/medical records: _____ * Who's e-mail address is this? _____	***CLINIC POLICY:*** ***Appointment reminders, recommended appointments and patient follow-up will be done by means of calls, voicemail, texts and/or e-mail***

Parents/Legal Guardians:

Name: _____ Relationship: DOB:	Phone #'s: _____(H) _____(C)	Place of Employment: _____ Work phone:_____	Home address: □ same as above
Name: _____ Relationship: DOB:	Phone #'s: _____(H) _____(C)	Place of Employment: _____ Work phone:_____	Home address: □ same as above

Emergency Contact (s):

Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach your family?
Name:	Relationship:	Home phone #	Cell Phone #	Are we able to contact this person in efforts to reach your family?

Insurance:

Primary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#
Secondary Insurance:	Primary Insured Name:	Relationship:	DOB:	ID# Group#

Preferences/Information:

Primary/Preferred Provider at CTMC:	Primary Pharmacy: Name:_____City:_____ Number:_____	Other siblings at FCTMC? * * *	*Hospital child was born at: *Other clinics in which patient has been seen at:

Name of person completing this form Name:	**I attest this information provided above is correct to the best of my knowledge:** Signature: Relationship to patient: *(Parent or legal guardian required)*	Date:

*****OVER*****

****Please read back side of form regarding important clinic policies****

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CTMC CLINIC POLICIES *To show your understanding, please initial each section of the policies below*

In compliance with the Federal Consumer Protection Act, Child & Teen Medical Center, P.A. (CTMC) wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your family.

1. You must present your insurance card at each visit.
2. Co-payments assigned by your insurance carrier are due at the time of service.
3. We will furnish you with a monthly statement of your account showing the amounts billed, and any payments and credits to the account
4. We will file most insurances. You are responsible for denied claims, and all patient responsibility amounts such as deductibles as per your insurance policy.
5. Payments for services are considered due and payable at the time of service unless active insurance is presented.
6. Payments are due within 30 days of billing unless payment plan arrangements are made with our Business Office.
7. Finance charges are incurred after 90 days at an 8% annual interest rate.
8. There is a returned check fee of $35.00
9. Telehealth visits (phone, e-mail and/or web-based audio visual)/specialist consultations in lieu of an office visit may be billed to your insurance and applicable deductible/co-payment amounts will be patient responsibility. Financial initials:_____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits due to me under the terms of my policy to Child & Teen Medical Center, P.A. I understand the clinic's charge may exceed the insurance company/Medicaid payment, and if greater than such, I will be responsible for paying that additional allowable amount. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done. Benefits initials:_____

OUTSIDE COSTS

Lab tests that need to be sent out, medical equipment and visits scheduled with specialty providers within our clinic will incur separate billing outside of Child and Teen Medical Center. All billing questions for the above listed entities will need to go through that specific entity. Child and Teen Medical Center does not administer billing for these items. **Outside costs initials:_____**

RELEASE OF INFORMATION

I hereby authorize Child & Teen Medical Center, P.A. to furnish information regarding my child's health care and medical history to insurance carriers and to other medical care providers to whom I might be referred by CTMC and to furnish any information necessary to complete any health forms I might submit on behalf of my child's school camp, athletic organization or the like. Release of Info initials:_____

CONTACT INFORMATION

Child & Teen Medical Center, P.A. may use my contact information for appointment reminders, follow up calls, satisfaction surveys and secure patient health information reporting through text, phone messages, and/or emails (private patient portal). You are consenting to receive directed and automated messages from us about you or your child's healthcare and hold CTMC and technology vendors harmless from any third-party claims, liability, damages or costs arising from your request to receive automated voice, text messages or from providing us, your healthcare provider, with a number that is not your own. We respect your need for privacy and will not send you telemarketing related messages or share your contact details with anyone. Contact consent initials:_____

NOTICE OF PRIVACY PRACTICES

This Notice describes how the medical information about you may be used and disclosed. Please review the privacy policy attached to the new patient clip board. Please let us know if you would like a copy for your records. Privacy Initials:_____

APPOINTMENT CANCELLATION POLICY

Your appointment time is reserved exclusively for you/your child. *We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to show up for their scheduled appointments (more than 3 times). Patients/parents who have missed multiple appointments may be asked to seek medical care elsewhere.*

To respect the needs of other patients, we require that you contact our office to reschedule at least 24 hours prior to your scheduled appointment time. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated. To cancel an appointment, please call our office. If you do not reach a representative, you may leave a voicemail. YOU MAY NOT CANCEL AN APPOINTMENT VIA EMAIL. Cancellation initials:_____

LATE/TARDY POLICY

If you are going to be more than 10 minutes late for your appointment, we request that you call our office. If the schedule allows, the appointment time will be shifted to accommodate the delay or you will be moved to walk-in status and not guaranteed your preferred provider. Depending upon the type of visit scheduled, we may request to reschedule the appointment. We work diligently to stay on schedule and suggest that you arrive 5-10 minutes prior to your appointment time to allow for any necessary paperwork. *Patients who are consistently late may be asked to seek medical care elsewhere*. Late Policy initials:_____

I agree to all clinic policies as described above:

Signature:_____ Relationship to patient:_____ Date:_____

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