LEAPClinics
LIVING EVERYDAY AS PURPOSED

2439 Manhattan Blvd. Suite 501-A, Harvey, LA 70058
Phone 504-569-LEAP (5327) | Fax: 504-323-3153
Leap@LeapClinics.com | www.LeapClinics.com

PATIENT INFORMATION

Patient's Name _____

Date of Birth: _____/_____/_____ **Sex (Circle):** Male or Female

Preferred Language (Circle): English, Spanish, Other: _____

Race (Circle): American Indian, Alaskan Native, African American, Asian, Caucasian, Hawaiian Native, Pacific Islander, Other (Please specify): _____

Ethnicity: Hispanic/Latino or Not Hispanic/Latino

***** If patient is over 18 years of age complete section below *****

Patient Cell Phone _____ **Patient Work Phone** _____

Patient Email Address _____

PARENT/GUARDIAN INFORMATION

Mother's Name _____

Date of Birth _____/_____/_____ **Genetic Mother:** Y/N **Live with Patient:** Y/N

Address _____

Cell Phone _____ **Work Phone** _____

Email Address _____

Father's Name _____

Date of Birth _____/_____/_____ **Genetic Father:** Y/N **Live with Patient:** Y/N

Address _____

Cell Phone _____ **Work Phone** _____

Email Address _____

RESPONSIBLE PARTY

Name _____

Date of Birth _____/_____/_____ **Social Security #** _____-_____-_____

Mailing Address _____

Cell Phone _____ **Work Phone** _____

PATIENT INSURANCE INFORMATION

PRIMARY

Insurance Company _____

Insured Name _____

Last First Middle

Insured Date of Birth _____/_____/_____

Insured Social Security# _____-_____-_____

Member ID# _____

Group # _____

Policy # _____

Patient's Relationship to Insured Party: Circle One

Self Child Spouse Other

SECONDARY/SUPPLEMENTAL

Insurance Company _____

Insured Name _____

Last First Middle

Insured Date of Birth _____/_____/_____

Insured Social Security# _____-_____-_____

Member ID# _____

Group # _____

Policy # _____

Patient's Relationship to Insured Party: Circle One

Self Child Spouse Other

I hereby authorize the above listed insurance companies to pay directly to Leap Pediatrics, LLC benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me outstanding greater than 30 days will be assessed a finance charge of 1 ½% per month. I authorize Leap Pediatrics, LLC to release information to the insurance company for my claims to be paid. Please attach a copy of insurance card. I authorize Leap Clinics to contact me by any method listed including my cell phone and/or email.

_____ _____

Signature Date

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PATIENT AUTHORIZATION AND CONSENT FORMS

Patient Name _____ Patient Date of Birth _____/_____/_____

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Leap Pediatrics, LLC is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

CONSENT FOR TREATMENT

I hereby give consent to Leap Pediatrics, LLC to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any assistant on the staff of Leap Pediatrics, LLC. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Leap Pediatrics, LLC recommends. This authorization will remain in effect until revoked in writing by the parent or legal guardian. **Initials _____**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION FOR BILLING & REIMBURSEMENT PURPOSES

I hereby authorize Leap Pediatrics, LLC to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.
Initials _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Leap Pediatrics, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. **Initials _____**

I have requested medical services from Leap Pediatrics, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. **Initials _____**

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. **Initials _____**

YOUR RESPONSIBILITY TO PARTICIPATE ACTIVELY IN YOUR OWN CARE OR TREATMENT

In addition to the responsibilities outlined above, your most important responsibility involves your active participation in your own care and treatment. We ask and expect, that you will implement the instructions and/or recommendations of our Practice's clinical staff members. We reserve the right to terminate any physician/patient relationship at any time for any reason. **Initials _____**

Add in: I understand that this consent form will be valid and remain in effect as long as I or my dependent receive medical care at Leap Pediatrics, LLC.

_____ _____

Parent Signature **Date Signed**

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PATIENT AUTHORIZATION AND CONSENT FORMS CONTINUED

NOTICE OF PRIVACY PRCTICES ACKNOWLEDGEMENT

We keep a record of health care services we provide to you. You may request to see and receive a copy of that record. You may also ask for correction of that record. We will not disclose your record to others unless you direct us to do so or unless the law compels us to do so. You may request to review your record or get more information about it by contacting our privacy officer. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Initials _____

PATIENT HIPAA RELEASE OF INFORMATION AND MEDIA RELEASE AUTHORIZATION FORM

I, the undersigned, hereby authorize Leap Pediatrics, LLC, its duly authorized employees, or agents, to take photographs of me and my child/family. I also authorize Leap Pediatrics, LLC, its duly authorized employees, or agents, to publish the following personal health information/story (e.g., information relating to the diagnosis, treatment, and health care services provided or to be provided to me and which identifies my name and other personally identifiable information) to be used in print media, on the radio, TV, the Leap Pediatrics, LLC website, blog, and other following social media platforms: Facebook, Instagram, Twitter, Pinterest, YouTube, or other electronic media without payment of any other consideration. I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws. I agree that I will not hold Leap Pediatrics, LLC responsible for any liability resulting from the use of my/my child's name, picture and/or likeness in the manner described above. I understand that I have a right to revoke this authorization by providing written notice to Leap Pediatrics, LLC. However, this authorization may not be revoked if Leap Pediatrics, LLC, its employees, or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for coverage of services.

Initials _____

PATIENT PORTAL

Our patient portal lets establish patients communicate more easily with us but is not intended for "Web Visits" or new problems. Instead, it will make regular communication and access to health information more flexible. The portal uses encryption to keep messages and information secure and can only be accessed by someone who knows the right password to log into the poral site. Usage is voluntary and free of charge. **DO NOT SEND ANY MESSAGE REQUIRING URGENT ATTENTION USING THE PATIENT PORTAL. If you are experiencing any emergency, please dial 911 or go to the nearest Emergency Facility.** I acknowledge that I have read and fully understand this consent form. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the patient portal.

Cell Phone Number: _____ **This cell number will be used for text reminders.**

Who is your cell phone provider? Please circle one below.

AT&T VERIZON METRO PCS BOOST T-MOBILE SPRINT OTHER: _____

_____ _____

Signature Date

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CLINIC POLICIES AND DISCLOSURES

NO SHOW POLICY

Please be advised Leap Clinics has a strict **"NO SHOW"** policy. We ask that you call 24 hours in advance to cancel an appointment. Our receptionist and/or automated reminder system confirm all appointments 24-48 hours in advance, so please make sure that we have the correct contact information including phone number and email address.

Failure to cancel an appointment, you will be charged $25.00. This fee CAN NOT be billed to your insurance company. It MUST be paid by the patient or patient account guarantor. Missing 3 appointments may result in dismissal from the practice. We apologize for the inconvenience, as we also must be considerate of other patients who may need an appointment.

I understand that I am responsible for any fees for missed/no show or appointment(s) cancelled with less than 24-hour notice. I understand these charges will not be billed to my insurance. I agree to pay these fees in full as outlined above.

_____ _____

Signature: Date:

PREFERRED PHARMACY for MEDICATIONS and MEDICATION REFILLS

In order to provide the best care for our patients, we must have a current preferred pharmacy of choice on file. This will aid our office staff in the timely delivery of medications and medication refills directly to the pharmacy. It is the ultimately responsibility of the Patient and/or Parent-Guardian to ensure that the pharmacy on file in the patient's chart is always the most up to date.

Failure to have a preferred pharmacy of choice on file, will result in a delay in medications being delivered to the pharmacy in a timely manner.

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Location (Cross Streets): _____

EMERGENCY CONTACTS

I, the undersigned, give permission to the staff and physicians of Leap Pediatrics, LLC, to speak to or give any health information to the person(s) listed below. I also give the following person(s) listed below permission to being my child to appointments. I understand that the caregiver will be required to make payments due for each visit at the time of service. I also understand it is my responsibility to notify Leap Pediatrics, LLC in writing for any caregiver changes.

Name: _____ Relationship to Patient:

Phone Number: _____ _____

Name: _____ Relationship to Patient:

Phone Number: _____ _____

Name: _____ Relationship to Patient:

Phone Number: _____ _____

Name: _____ Relationship to Patient:

Phone Number: _____ _____

Name: _____ Relationship to Patient:

Phone Number: _____ _____

Name: _____ Relationship to Patient:

Phone Number: _____ _____

Name: _____ Relationship to Patient:

Phone Number: _____ _____

_____ _____

Signature Date