

Brigham Pediatrics
 980 S. Medical Dr. Ste #2
 Brigham City, Utah 84302
 P 435-734-2433 F 435-734-0059



Farr West Pediatrics
 2850 N 2000 W Ste #102
 Farr West, Utah 84404
 P 801-732-0780 F 801-732-0847

PATIENT(S) INFORMATION:

Full Legal Name (First, Middle, Last): _____ Birth Sex: _____ Hispanic/Latino Not Hispanic
 Preferred Name(Optional): _____ Gender: _____ DOB: ____/____/____ Language: _____ Race: _____

Full Legal Name (First, Middle, Last): _____ Birth Sex: _____ Hispanic/Latino Not Hispanic
 Preferred Name(Optional): _____ Gender: _____ DOB: ____/____/____ Language: _____ Race: _____

Full Legal Name (First, Middle, Last): _____ Birth Sex: _____ Hispanic/Latino Not Hispanic
 Preferred Name(Optional): _____ Gender: _____ DOB: ____/____/____ Language: _____ Race: _____

Full Legal Name (First, Middle, Last): _____ Birth Sex: _____ Hispanic/Latino Not Hispanic
 Preferred Name(Optional): _____ Gender: _____ DOB: ____/____/____ Language: _____ Race: _____

Full Legal Name (First, Middle, Last): _____ Birth Sex: _____ Hispanic/Latino Not Hispanic
 Preferred Name(Optional): _____ Gender: _____ DOB: ____/____/____ Language: _____ Race: _____

GUARDIANSHIP

PRIMARY CONTACT: LEGAL PARENT/GUARDIAN 1:
 Full Legal Name: _____ DOB: ____/____/____ Social Security: _____ - _____ - _____ Home Phone: (____) _____
 Address: _____ City / State: _____ / _____ Zip: _____ Cell Phone: (____) _____
 Email: _____ Employer: _____ Work Phone: (____) _____

SECONDARY CONTACT: LEGAL PARENT/GUARDIAN 2:
 Full Legal Name: _____ DOB: ____/____/____ Social Security: _____ - _____ - _____ Home Phone: (____) _____
 Address: _____ City / State: _____ / _____ Zip: _____ Cell Phone: (____) _____
 Email: _____ Employer: _____ Work Phone: (____) _____

PARENT/GUARDIAN/STEP PARENT/OTHER 3:
 Full Legal Name: _____ DOB: ____/____/____ Social Security: _____ - _____ - _____ Home Phone: (____) _____
 Address: _____ City / State: _____ / _____ Zip: _____ Cell Phone: (____) _____
 Email: _____ Employer: _____ Work Phone: (____) _____

PARENT/GUARDIAN/STEP PARENT/OTHER 4:
 Full Legal Name: _____ DOB: ____/____/____ Social Security: _____ - _____ - _____ Home Phone: (____) _____
 Address: _____ City / State: _____ / _____ Zip: _____ Cell Phone: (____) _____
 Email: _____ Employer: _____ Work Phone: (____) _____

EMERGENCY

EMERGENCY CONTACT NOT LIVING WITH YOU:
 Full Legal Name: _____ Relationship to patient: _____ Home Phone: (____) _____
 Address: _____ City / State: _____ / _____ Zip: _____ Cell Phone: (____) _____
 Email: _____ Work Phone: (____) _____

EMERGENCY CONTACT NOT LIVING WITH YOU:
 Full Legal Name: _____ Relationship to patient: _____ Home Phone: (____) _____
 Address: _____ City / State: _____ / _____ Zip: _____ Cell Phone: (____) _____
 Email: _____ Work Phone: (____) _____

INSURANCE

Primary Ins: _____ Policy ID #: _____ Group #: _____ Effective Date: _____
 Co-pay Amt: _____ Relationship to Policy Holder: _____
 Policy Holder's Name: _____ DOB: ____/____/____ Sex: _____ Social Security: _____

Secondary Ins: _____ Policy ID #: _____ Group #: _____ Effective Date: _____
 Co-pay Amt: _____ Relationship to Policy Holder: _____
 Policy Holder's Name: _____ DOB: ____/____/____ Sex: _____ Social Security: _____

AUTHORIZATION

NAME OF PERSON(S) AUTHORIZED TO BRING YOUR CHILD TO APPOINTMENTS ON YOUR BEHALF:

Full Legal Name: _____ Relationship to patient: _____ Phone: (____) _____ Cell Phone: (____) _____

Full Legal Name: _____ Relationship to patient: _____ Phone: (____) _____ Cell Phone: (____) _____

Full Legal Name: _____ Relationship to patient: _____ Phone: (____) _____ Cell Phone: (____) _____

Full Legal Name: _____ Relationship to patient: _____ Phone: (____) _____ Cell Phone: (____) _____

NO SHOW POLICY

Due to a significant increase in patients and families not showing up for appointments with minimal or no notice, we have implemented the following policy:

A charge of \$45.00 per missed appointment will be applied. This includes appointments missed with less than 2 hours' notice for same-day appointments and less than 24 hours' notice for all other appointments. Mental health evaluation appointments, due to their longer duration, will incur a \$90.00 charge for a missed appointment.

These fees must be paid prior to scheduling your next appointment.

For families scheduling appointments on the same day with multiple children, each missed appointment for each child will result in a separate \$45.00 charge.

Five missed appointments for your family, without appropriate cancellation notice within one year, and/or a total of seven missed appointments ever, will result in discharge from the practice.

I have read Brigham/Farr West Pediatrics' No Show Policy. I understand that failing to show up for a scheduled appointment without appropriate notice as outlined above will result in a charge for each missed appointment. I consent to have my account charged accordingly for any missed appointments.

SIGNATURE: _____ PRINT NAME: _____ TODAYS DATE: _____

COMMUNICATION

I authorize Brigham/Farr West Pediatrics to contact me using the methods listed below for the purpose of communicating personal health information, including but not limited to lab and other test results as well as billing information. By providing my contact information, I consent to Brigham/Farr West Pediatrics, its assignees, and third-party collection agencies using the contact information I have provided to communicate with me, including placing calls to my listed methods of contact, leaving voice or text messages, and using pre-recorded/artificial/voice messages and/ or auto-dialing devices.

I also understand that Brigham/Farr West Pediatrics may contact me through my secure patient portal account. If attempts to contact me directly are unsuccessful, I also authorize Brigham/Farr West Pediatrics to send a notice to my home address.

Furthermore, I acknowledge that despite any preferences marked on this authorization form, Brigham/Farr West Pediatrics and its assignees reserve the right to use these, and any other emergency contact information I provide, as communication methods in any needed or urgent situations for patient safety and medical needs, at the discretion of any member of the medical and billing team at Brigham/Farr West Pediatrics.

Email(s) Authorized for Communications: _____

Phone Number Authorized for Communications (Calling, Leaving Messages, and/or Texting) _____

INITIALS: _____

PRIVACY PRACTICE

NOTICE OF PRIVACY PRACTICES:

I acknowledge that Brigham/Farr West Pediatrics provided me with a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

SIGNATURE: _____ PRINT NAME: _____ TODAYS DATE: _____

MEDICAL RECORDS

Confidentiality of Medical Records:

At Brigham/Farr West Pediatrics, safeguarding patient information is a top priority. We employ robust measures to ensure the confidentiality and protection of electronic health records and computer systems. However, it is important to acknowledge that no system is entirely immune to unauthorized access or hacking attempts. Therefore, while we take every reasonable precaution, we cannot be held liable for any unauthorized access or breaches of our electronic health records or computer systems. By choosing to receive our services, you acknowledge and accept the inherent risks associated with storing data in any electronic health record system.

Access to Medical Records:

I understand that authorized personnel at Brigham/Farr West Pediatrics will have access to my medical records through computer systems. The office adheres to stringent safeguards mandated by federal, state, and local laws, as well as internal policies, to protect the confidentiality and security of patient information. These safeguards are designed to ensure that only authorized individuals have access to medical records, and that all access is monitored and compliant with privacy regulations.

By signing below, I confirm that I have read and understood the policies regarding the confidentiality of medical records and access to them. I acknowledge the risks associated with electronic health records and consent to the storage and access of my medical information as described above.

INITIALS: _____

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COMPUTER DATA

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