DOCTOR at your DOOR

NEW PATIENT APPLICATION

Patient's information:

	Name	Sex	DOB	Age .
Child #1	_____	_____	_____	_____
Child #2	_____	_____	_____	_____
Child #3	_____	_____	_____	_____
Child #4	_____	_____	_____	_____

Past medical history:

	Medical conditions	Hospitalizations/surgeries
Child 1:	_____	_____
Child 2:	_____	_____
Child 3:	_____	_____
Child 4:	_____	_____

Please list all medications/supplements your child is taking, and any allergies your child has:

	Medications/vitamins/supplements	Allergies to medications or foods
Child 1:	_____	_____
Child 2:	_____	_____
Child 3:	_____	_____
Child 4:	_____	_____

Parent information:

Parent/guardian #1 Name: _____

Cell phone number: _____ Email: _____

Address: _____ City and zip: _____

Any medical conditions that *you* or *your parents* (your child's grandparents) have:

_____

Parent/guardian #2 Name: _____

Cell phone number: _____ Email: _____

Address: _____ City and zip: _____

Any medical conditions that *you* or *your parents* (your child's grandparents) have:

_____

Who referred you to our practice? _____

DOCTOR at your DOOR

OFFICE POLICIES

Scheduling Appointments: To schedule an appointment, please call or text 720-418-1705. We often have same-day, after-hours, and weekend appointments available.

Telemedicine Services (medical visits over the phone) are available at a rate of $100 per visit. If you could like to schedule a telemedicine visit, please call or text us with your child's age and primary concern. We can typically perform a telemedicine visit urgently within a few hours. Not all conditions can be treated by telemedicine.

Email Communication: Email is not secure and not a preferred method of communication. It is ok to email for non-urgent matters. For medical questions, please call and schedule a visit, either in person or via phone.

Financial Policy: Payment is due in full at the time of service. We accept cash, checks, credit/debit cards, HSA/FSA cards, PayPal, and Venmo. *Initial* _____

Doctor At Your Door is **out of network** with all insurance companies. We can provide you with a Superbill (a medical receipt) to submit to your insurance company for reimbursement based on your out of network coverage. We are unable to see patients who have Medicare or Medicaid. *Initial* _____

We charge a **$35 fee** for all returned checks and a **$100 fee** for all appointments cancelled with less than 24 hours notice. *Initial* _____

Privacy Practices: Doctor At Your Door (DAYD) will keep an electronic record of each visit. DAYD will not share your child's medical information with any other provider unless I consent. By initialing here *(initial)* _____ I am consenting to allow DAYD to share my child's information with other providers who will be providing medical care, including other physicians and complementary and alternative medical providers.

Vaccine Policy: Doctor At Your Door recommends following the CDC schedule for routine vaccinations, but will examine and treat all children regardless of their vaccination status. DAYD will not be held liable for any adverse outcome related to vaccinating or not vaccinating. Vaccines can be given at home and will incur an amount in addition to the visit fee. I prefer (*initial one)* Routine vaccines _____ Delayed/alternate schedule _____ No vaccines _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES / CONSENT TO TREAT

I, *(Parent/ Legal Guardian)*: _____ hereby acknowledge that I read and reviewed a copy of Doctor At Your Door's Privacy Practices and Office Policy and fully understand this consent form. I am providing consent for Doctor At Your Door LLC and any of its associates (herein DAYD) may examine and treat my child at home. I am authorized to allow this. I am responsible for providing all relevant medical information to DAYD. I understand the risks associated with electronic communications between my physician and me. I understand that I am financially responsible for the charges that I incur during my child's treatment under the care of DAYD. I understand that I must ask the doctor for a superbill and submit it to insurance myself if I wish to be reimbursed, and I understand that all insurance companies reimburse at different rates and reimbursement is not guaranteed. I have read and agree to the financial policy. I have been proactive about asking questions related to this consent agreement. My questions have been answered and I understand and concur with the information provided in the answers. This form will be scanned electronically and kept in my child's file in lieu of the original, and I may ask for a copy at any time.

Signature: _____ Date: _____

Printed name: _____