Kids First Pediatric Clinic, LLC
18603 Willamette Drive, West Linn, OR 97068
Phone: (503) 699-3313 Fax: (503) 699 - 3365 Website:
www.kids1stclinic.com

Patient(s) Update Information Form

1. Patient Name_____Date of Birth_____Gender_____

2. Patient Name_____Date of Birth_____Gender_____

3. Patient Name_____Date of Birth_____Gender_____

Address _____ _____

Street City State Zip

GIVE BOTH PARENTS INFORMATION

Parent Name_____**Other Parent Name** _____
Soc Sec #_____Soc Sec # _____
Date of Birth_____Date of Birth _____
Driver's License#_____Driver's License#_____
Employer_____Employer _____
Occupation _____ Occupation _____
Home Phone _____ Home Phone _____
Work Phone_____Work Phone _____
Cell Phone _____ Cell Phone _____
Email Addresses: _____

1. **HIPAA (Health Insurance Portability and Accountability Act)** I hereby acknowledge that I have been presented with a copy of A Kids First Pediatric Clinic Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to (ABFP) requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.
   Parent/ Guardian Initials_____

2. **Kids First Pediatric Clinic Financial Obligation Policy**: I have read, understand, and will comply with the Financial Obligation Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions, Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.
   Parent/ Guardian Initials_____

3. **Appointment Policy/ Office Policies:** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic/ Appointment policies handout and understand my responsibilities. I have read and understand them.
   Parent/ Guardian Initials_____

Has your insurance information changed within the last six months? Please circle one. * **YES** **NO**
*If yes, Please provide your new insurance information to the front desk personnel.
The office policies and protocols will be updated periodically as the practice grows, and changes will be made accordingly.
I acknowledge that I have read this document in its entirety and fully understand it and will comply with all of Kids First Pediatric Clinic policies and protocols. I also acknowledge I have been given copies of all the policies mentioned above, and I was given the opportunity to ask any questions.

Print Parent/Guarantor name:_____Signature:_____Today's Date: _____