Dorin Kemmerle, MD LLC dba Sprout Pediatrics
4350 Commercial St SE, Salem, OR 97302
(503) 877-4485 (888) 977-1263
SproutPediatrics.com

Patient Information and Consent

Child's legal name: ____ Date of birth: ____/____/____

Likes to be called: ____ Gender*: M F ___________

Language(s)*: ___________________________Race*: ________________ Ethnicity*: _________________

Address: ____ City: __________________ Zip: ________

Phone #1: ______________________________________ cell home work Whose? ________________
☐ Permission to leave messages

Phone #2: ______________________________________ cell home work Whose? ________________
☐ Permission to leave messages

Email #1: ____ Whose? ________________

Email #2: ____ Whose? ________________

Mother/Guardian: ____ Date of birth: ____/____/____

Father/Guardian: ____ Date of birth: ____/____/____

Please describe living or custody arrangements: ____

____

Party responsible for payment: ☐ Mother ☐ Father ☐ Both Parents ☐ Guardian ☐ Self

I have requested medical services from Sprout Pediatrics and authorize Dr. Kemmerle and her staff to examine, perform testing and treat the above named patient(s) as deemed necessary for the benefit of the patient(s). I understand that by making this request, I become fully financially responsible for all charges incurred. All professional services rendered are charged to the patient and are due at the time of service. Only the copay, coinsurance and/or deductible are due at the time of service IF these services are usually covered by health insurance, Sprout Pediatrics is a participating provider, and the insurance company verifies coverage. I understand I must present my current insurance card to be scanned at each visit and that my insurer, not Sprout Pediatrics, determines eligibility and benefits. I also understand that I am responsible for any amount not covered by insurance and for communicating with the insurer regarding my plan benefits. I authorize Sprout Pediatrics to bill my insurance on my behalf and authorize and direct my insurance carrier(s) to issue payment directly to Sprout Pediatrics for medical services rendered.

____ ________________
Signature of patient or responsible party Date

____ ________________
Printed name of responsible party Relationship

- Information such as race, ethnicity, gender & employment are necessary components of any complete medical record, and also allow us to monitor and ensure that Sprout Pediatrics provides equally excellent care to all patients. We do not provide identifying information to outside entities.

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Patient Information and Consent (page 2)

Above child's legal name: ____ Date of birth: ____/____/____

Additional children for whom all of the above information applies:

Child's legal name: ____ Date of birth: ____/____/____

Likes to be called: ____ Gender: M F

Child's legal name: ____ Date of birth: ____/____/____

Likes to be called: ____ Gender: M F

Child's legal name: ____ Date of birth: ____/____/____

Likes to be called: ____ Gender: M F

Child's legal name: ____ Date of birth: ____/____/____

Likes to be called: ____ Gender: M F

Alternate or Emergency Contacts (optional):

Name: ____ Relationship: ______________________

Phone: ____ cell home work ☐ May act as my proxy*

Name: ____ Relationship: ______________________

Phone: ____ cell home work ☐ May act as my proxy*

**By checking this box I authorize this person to seek care for my child and consent on my behalf to treatment, including hospitalization & vaccinations. Sprout Pediatrics has my permission to disclose information about my child necessary for the person named above to give informed consent. Dr. Kemmerle will communicate with the person named above and provide a visit summary via the patient portal, but it is not necessary or expected that Dr. Kemmerle contact me. I further indemnify Sprout Pediatrics for any disagreements I may have with the person named above. I understand that payment for the visit is my responsibility and will be charged to the credit card on file. This authorization will remain valid until revoked in writing.* Initials: ______