

WEST ALABAMA PEDIATRICS

Account #. _____ Date _____

Patient's Nickname: _____ Social Security #: _____

Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Sex: M F

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown

Race: African American Asian Caucasian Hispanic Native American Pacific Islander

Language: English Spanish German Other: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling: _____ DOB _____ Sibling: _____ DOB _____

Sibling: _____ DOB _____ Sibling: _____ DOB _____

Mother Stepmother Guardian
(Circle One)

Father Stepfather Guardian
(Circle One)

Name: _____

Name: _____

DOB: _____

DOB: _____

Home/Cell Phone: _____

Home/Cell Phone: _____

Work Number: _____

Work Number: _____

Email Address: _____

Email Address: _____

Employer: _____

Employer: _____

Occupation: _____

Occupation: _____

Social Security #: _____

Social Security #: _____

Driver's License #: _____

Driver's License #: _____

Marital Status: _____

Marital Status: _____

Select preference for Appointment Reminders: **Text** or **Call**

Can confidential messages be left on your Home/Cell phone #? **Yes No**

Patient's cell phone # if age 14 years or older: _____

Emergency Contact Person: _____ Relation: _____ Phone # _____

Primary Insurance

Secondary Insurance

Insurance Company: _____

Insurance Company: _____

Contract #: _____

Contract #: _____

Group #: _____

Group #: _____

Effective Date: _____

Effective Date: _____

Policy Holder: _____

Policy Holder: _____

Policy Holder DOB: _____

Policy Holder DOB: _____

Relationship to Patient: _____

Relationship to Patient: _____

CoPay Amount: _____

CoPay Amount: _____

WEST ALABAMA PEDIATRICS
Insurance and Office Policies

All professional services provided by West Alabama Pediatrics are charged to the patient. We file most major insurance companies. Please contact your insurance company and verify that we participate in your group plan. It is the patient/parents responsibility to make sure we have the correct insurance information on file. We will gladly file your insurance for you. However, patients are responsible for all fees regardless of the insurance coverage.

All co-pays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. In cases of divorce or separation, where each parent is responsible for a portion of the bill, we do not "split" account balances. There will be a \$10.00 billing fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, MasterCard, American Express and Discover.

You should receive a statement on your account by the first of every month. We expect our patients to pay their account balance in full. Please notify our office manager immediately if you have unusual financial circumstances and need to make special financial arrangements. We are willing to work with you on an arranged payment plan. An account that is delinquent for more than 90 days will be sent to collections, and any costs incurred thereby will be the responsibility of the patient (parent of responsible party). If your account is turned over for collection, we may no longer continue to provide medical care for your child. No well visits or immunizations will be given if you have an outstanding account balance or if you have not made arrangements for your account to be paid in full.

It is the patient's responsibility to know your insurance benefits and whether the physician you see is or is not a preferred provider. Some insurance require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours during normal business hours if you are seeing or have seen another physician. We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance or is considered an emergency.

You have 30 days to add a new baby to your insurance. Please contact your HR department and make sure your baby is added to your policy before the baby's first visit to our office. If we are unable to verify coverage, you will be responsible for paying the office visit in full.

In order to release medical records, we must have a release signed by a parent or guardian on file. There is a fee for copying of medical records that includes \$1.00 per page for the first 25 pages and .50 for each page thereafter. In order to release your medical records to another physician for the purpose of changing physicians, we request that the balance of your account be paid in full. Accounts that are not paid in full or arrangements made to do so will be treated as a bad debt and will be forwarded to a collection agency.

There is a fee and a 48 hour waiting period on all medical forms, including blue cards (immunization record) not requested at the time of a check-up. A form fee list and price is posted at the front desk.

There is a \$10.00 fee associated with after hour's telephone calls. Please read our Telephone Policy to avoid unnecessary costs. There is a \$30.00 No Show/Cancellation fee if you do not call and cancel your appointment prior to the scheduled appointment time. There is a \$30.00 fee on any returned checks.

Agreement to Accept Financial Responsibility,
Insurance Authorization and Assignment of Benefits

I hereby authorize payment directly to West Alabama Pediatrics for the medical services rendered to myself or my dependents. I hereby authorize West Alabama Pediatrics to furnish medical information to my insurance carriers for payment of claims. I understand that the charges occurred at each office visit are for my continued healthcare. I understand that I am financially responsible to the physician for charges not covered by my insurance company. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due it may be turned over to a collection agency, an attorney or small claims court for collection. I agree to pay 28% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

Signature of Parent or Guardian

Relationship to Child

Date

WEST ALABAMA PEDIATRICS

ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from WEST ALABAMA PEDIATRICS. You agree that all records concerning your care within WEST ALABAMA PEDIATRICS shall remain the property of WEST ALABAMA PEDIATRICS.

You understand and agree that such information is used for:

- (1) **Your treatment** – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient.
- (2) **Payment for your services** – billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account.
- (3) **Routine healthcare operations** – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of WEST ALABAMA PEDIATRICS; AND
- (4) **Medical research and educational purposes** -- You acknowledge that you have been provided with a WEST ALABAMA PEDIATRICS Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that WEST ALABAMA PEDIATRICS reserves the right to change the Notice and that WEST ALABAMA PEDIATRICS will provide you with a revised Notice when you come to WEST ALABAMA PEDIATRICS.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

WEST ALABAMA PEDIATRICS:

_____ Agree _____ Not Agree _____ N/A

Patient Signature: _____

Date: _____

WEST ALABAMA PEDIATRICS
Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Name of Practice: **WEST ALABAMA PEDIATRICS**

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent Name: _____ **Date of Birth:** _____

Parent Name: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1. Name of Personal Representative: _____
DOB: _____ Relationship to patient: _____
Phone #: _____

2. Name of Personal Representative: _____
DOB: _____ Relationship to patient: _____
Phone #: _____

3. Name of Personal Representative: _____
DOB: _____ Relationship to patient: _____
Phone #: _____

4. Name of Personal Representative: _____
DOB: _____ Relationship to patient: _____
Phone #: _____

***Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.

***Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

***Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

WEST ALABAMA PEDAITRICS
Attn: Privacy Manager
1060 Fairfax Park, Suite C
Tuscaloosa, AL 35406

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Parent Signature: _____ Date: _____

WEST ALABAMA PEDIATRICS
PATIENT'S RIGHTS AND RESPONSIBILITIES

Child's Name: _____ DOB: _____

Welcome to the West Alabama Pediatric team!! Join us as active members of your child's health care team by reviewing the Patient/Family Rights and Responsibilities listed below.

Children and their parent(s)/guardian(s) have the **RIGHT** to:

- Be given considerate, respectful, and compassionate care
- Be treated fairly regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment
- Have their cultural and personal values, beliefs, and wishes respected
- Have treatment and other patient information kept private. Only by law may records be released without permission.
- Access care easily and in a timely manner
- Share in developing their plan of care/treatments
- Information about clinical guidelines used in managing their care
- Information about provider(s) work history and training
- Information about practice services
- Complain and have the complaint reviewed without affecting their care. If you have a problem you may talk directly with the practice manager.
- Know about laws that relate to their rights and responsibilities

Children and their parent(s)/guardian(s) have the **RESPONSIBILITY** to:

- Treat those giving them care with dignity and respect
- Give providers accurate and complete information they need in order to provide the best possible care
- Ask their provider questions about any diagnosis and/or treatment
- Help develop and follow the agreed-upon treatment plan for their care, including medications
- Tell their provider about medication changes, including medication given by other providers
- Take responsibility for the consequence of refusing care or not following treatment instructions
- Keep and be on time for all appointments. Patients should call the office as soon as possible if they need to cancel or reschedule an appointment.
- Inform the office about their insurance coverage and any changes to it, or any problems with paying fees
- Openly report concerns about quality of care to the practice manager
- Let the office know about any changes to their contact information (name, address, phone numbers) and to keep an updated "release of information" list
- Refrain from taking pictures/videos/recordings without permission from the staff

Parent's Signature: _____ Date: _____