WEST ALABAMA PEDIATRICS

Account #. ___________________ Date _______________

Child'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: _______________________

Patient lives with: ____________________ Primary contact #:____________________Alternate #:_______________

Sibling: ____________________ DOB ______________ Sibling: ____________________ DOB ________________

Sibling: ____________________ DOB ______________ Sibling: ____________________ DOB ________________

Emergency Contact Person: ________________________ Relation: ___________________ Phone # _____________

Mother Stepmother Guardian
(Circle One)

Name: _______________________________________

Home Phone: ________________________________

Work Number: _______________________________

Cell Number: ________________________________

Email Address: ______________________________

Employer: ___________________________________

Occupation: _________________________________

Social Security #: ____________________________

Marital Status: _______________________________

Father Stepfather Guardian
(Circle One)

Name: _______________________________________

Home Phone: ________________________________

Work Number: _______________________________

Cell Number: ________________________________

Email Address: ______________________________

Employer: ___________________________________

Occupation: _________________________________

Social Security #:____________________________

Marital Status: _______________________________

Primary Insurance

Insurance Company: ___________________________

Contract #: __________________________________

Group #: ____________________________________

Effective Date: _______________________________

Policy Holder: ________________________________

Policy Holder DOB: ____________________________

Relationship to Child: __________________________

CoPay Amount: _______________________________

Secondary Insurance

Insurance Company: ___________________________

Contract #: __________________________________

Group #: ____________________________________

Effective Date: _______________________________

Policy Holder: ________________________________

Policy Holder DOB: ____________________________

Relationship to Child: __________________________

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**

Effective 3/17/17

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:** _______________

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: ____
   Address/Phone: ____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other ____________________

2. Name of Personal Representative: ____
   Address/Phone: ____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other ____________________

3. Name of Personal Representative: ____
   Address/Phone: ____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other ____________________

4. Name of Personal Representative: ____
   Address/Phone: ____
   Relationship to patient: ☐ Spouse ☐ Parent(s) ☐ Child ☐ Other ____________________

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative, including but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc.
- **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 PEDIATRICS
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.

____ ____________________
Patient Signature Date

Copies of signed authorizations are available upon request.