PATIENT INFORMATION

Name of Patient: _____
First Middle Last

***please check each item below for required insurance reporting:**

Ethnicity: ☐ Hispanic/Latino ☐ non-Hispanic ☐ unknown ☐ decline to answer **Preferred language**:_____

Race: ☐ white ☐ black/African-American ☐ American Indian ☐ Pacific Islander ☐ other ☐ decline to answer

Sex: ☐ male ☐ female

Address: _____City: _____ State: ____ Zip: _____

Date of Birth: _____ Social Security#: _____ Home Phone: _____

Preferred Email: _____

PARENT INFORMATION

Mother's Full Name: _____ Mother's Date of Birth _____

Mother's Social Security #: _____ Mother's Cell #_____

Mother's Employer: _____ Mother's Work # _____

Father's Full Name: _____ Father's Date of Birth _____

Fathers' Social Security #: _____ Father's Cell # _____

Father's Employer: _____ Father's Work # _____

***If both natural parents do not share joint custody of patient, please explain the custody arrangements** (shared, exclusive, temporary, foster, none)_____

ADDITIONAL INFORMATION

How would you like us to contact you? home phone (**H**) cell (**C**) text to cell (**T**) preferred email (**E**)

Reminders? H C T E **Medical/Labs?** H C T E **General notice?** H C T E **Pt. portal?** C T E

please circle your choice for each

Emergency Contact: _____ Relationship: _____ Phone/Cell #: _____

Do you give permission for another person (besides those listed as mother and father) to bring your child to the doctor? ☐Yes ☐No

If yes, please list their names: _____

Your Relationship to Patient: _____ If you are not the natural parent, do you have legal custody of this patient and the authority to be making medical decisions for this child? ___Yes ___No

Your Signature: _____ Date: _____

This practice strongly believes in the safety and benefits of routine childhood vaccinations.
***If you do not intend for this child to receive the required vaccines** for attending public schools or do not plan to follow the recommended schedule, please notify your child's provider today.*

INSURANCE & BILLING INFORMATION

Billing address: ☐patient home; ☐other (who/where?): _____

Primary Insurance: _____ Insurance ID: _____

Group #: _____ Subscriber/Relationship: _____ Date of Birth: _____

****

Secondary Insurance: _____ Insurance ID: _____

Group #: _____ Subscriber/Relationship: _____ Date of Birth: _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT, & RELEASE OF RECORDS

- ❑ I agree to permit authorized personnel of *Cumberland Pediatric Associates, PC* to perform routine medical treatment, examinations, laboratory tests, and emergency procedures as deemed necessary by the providers in this office.
- ❑ I hereby assign my insurance benefits to be paid directly to Cumberland Pediatric Associates. I also authorize the providers and his/her designee to release my information acquired in the course of my examination and treatment necessary to process claims and/or coordinate care with other health practitioners.
- ❑ I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that if my account becomes delinquent, my account could be referred to an outside collection agency. If this happens, I would be responsible for all court costs, attorney's fees and collection costs associated with recovering my account.
- ❑ I am aware the practice's **"Notice of Privacy Practices"** is always available in waiting areas and on the practice website.

I agree that this authorization is valid regardless of when I receive services at this office and that I am the patient or authorized to sign this document.

_____ _____

Patient or Authorized Party Signature ***Date***

NEEDLE STICK POLICY

An employee of the clinic could be stuck with a needle while drawing your child's blood, or sustain some other injury exposing the employee to potentially infectious materials from your child. To protect against possible transmission of blood borne disease, such as the Hepatitis B virus and Human Immunodeficiency Virus (HIV/AIDS), by signing below, I understand it may be necessary for my child's blood to be tested while they are a patient of Cumberland Pediatric Associates. These test results will be kept confidential as required by state law. The testing would be done at no charge.

Signature of Parent/Guardian: _____ Date: _____

FINANCIAL AND MANAGED CARE POLICY STATEMENT

Cumberland Pediatric Associates, PC adheres to the policies below. The patient/responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

- Bring your insurance card to every visit.
- **Co-payments are expected to be paid at the time of check-in regardless of who brings the child.**
- You are required to pay your copayment, coinsurance, or deductible at the time services are rendered. Payment can be made by cash, check or credit card. If you do not bring your payment to your visit, then that day's visit will be required to be paid in full at the time of the visit. **Unpaid copayments will be charged an additional $25 fee.**
- If you are in an insurance plan where we don't participate, our office will be happy to file the claim as a courtesy to you; however, payment in full is expected at the time of service.
- Patients with **high deductible** ($1000 or more) plans are required to pay the following fees prior to their doctor visit: $100.00 for first new patient visit and $50.00 for each subsequent visit. Patients will be refunded or billed for additional amounts as appropriate after claim(s) are processed by their insurance company.
- Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
- Not all services are covered benefits of all insurance plans. The patient/responsible party has the responsibility of verification of applicable coverage. If you are unsure you can call the insurance company member services department, the number should be on your insurance card.
- The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at time of service.
- Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.

We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). Returned checks and balances older than 45 days may be subject to additional collection fees.

We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today's appointment. Thank you for your understanding and cooperation with this policy.

I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.

_____ _____

Responsible Party Signature ***Date***

Patient name if different from Responsible Party: _____

Consent to Treat in the Absence of Parent or Legal Guardian

Purpose: This form may be used to allow an adult other than parent or legal guardian serve as a decision maker for routine medical care and services at Pediatric & Adolescent Health Professional.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered under the care of a decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a decision maker, please review and complete the following form authorizing a decision maker to consent to and authorize medical treatment or services for and to be involved n the care of your child/children.

AUTHORIZATION

I hereby appoint _____ _____

NAME RELATIONSHIP

I hereby appoint _____ _____

NAME RELATIONSHIP

as a decision maker to consent to and authorize routine health care treatment and services for my child/children. Routine medical care and intervention may include, but are not limited to: medical evaluation, physical exam, lab work (throat swabs, wart treatment, and suture removal) and immunizations

Child's Name _____ DOB _____

LIMITATIONS:

Identity below any specific limitations on the kinds of medical services for which this authorization is given. _ NONE

The individual appointed is permitted to make decisions or consent to care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below.

Only one parent's signature is required.

_____ _____

(Signature or Parent or Legal Guardian) (Signature of Parent or Legal Guardian)

_____ _____

(Date) (Date)