PEDIATRIC ASSOCIATES OF SOUTHWEST MISSOURI

REGISTRATION

Children's Information Date:_______

Name:___________________________________ DOB: ___/___/____ ☐ Male ☐ Female

Social Security #:__________________________

Race: ☐Asian ☐Chinese ☐Filipino ☐Japanese ☐African American ☐American Indian or Alaska Native ☐Native American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Multiracial ☐Hispanic ☐Other____________

Language: _______________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Name:___________________________________ DOB: ___/___/____ ☐ Male ☐ Female

Social Security #:__________________________

Race: ☐Asian ☐Chinese ☐Filipino ☐Japanese ☐African American ☐American Indian or Alaska Native ☐Native American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Multiracial ☐Hispanic ☐Other____________

Language: _______________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Name:___________________________________ DOB: ___/___/____ ☐ Male ☐ Female

Social Security #:__________________________

Race: ☐Asian ☐Chinese ☐Filipino ☐Japanese ☐African American ☐American Indian or Alaska Native ☐Native American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Multiracial ☐Hispanic ☐Other____________

Language: _______________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Name:___________________________________ DOB: ___/___/____ ☐ Male ☐ Female

Social Security #:__________________________

Race: ☐Asian ☐Chinese ☐Filipino ☐Japanese ☐African American ☐American Indian or Alaska Native ☐Native American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Multiracial ☐Hispanic ☐Other___________

Language: _____________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Mother's Information

Mother's Name:______________________________ DOB:___________ SS # ______________

Street Address:_________________________City______________State_______Zip__________

Phone Numbers: Home_______________Cell________________Work_________________

Employer:_________________________ Email Address:_____________________________

Father's Information

Father's Name:______________________________ DOB:___________ SS # ______________

Street Address:_________________________City______________State_______Zip__________

Phone Numbers: Home_______________Cell________________Work_________________

Employer:_________________________ Email Address:_____________________________

Child lives with: ☐ Parents ☐ Mother ☐ Father ☐Other__________________________

Emergency Contact

Name:_________________________________ Relationship to Patient:___________________

Phone Numbers: Home____________________Cell_________________Work______________

Street Address:______________________City_______________State_______Zip___________

Insurance Information

Primary:

Insurance Company Name:____________________ ☐ No Insurance

ID #__________________________Group #________________________

Primary Policy Holder
Name:______________________DOB_____________Employer_______________________

Claims Address:_____________________________

Secondary:

Insurance Company Name:____________________ ☐ No Insurance

ID #__________________________Group #________________________

Primary Policy Holder
Name:______________________DOB_____________Employer_______________________

Claims Address:_____________________________

Financial Agreement:

I, the responsible party for the above child/children, understand that I am responsible for any charges that are incurred due to the services provided in this office. I understand that the office will file any insurance that I may provide on my behalf; however anything that is not covered by my insurance is my responsibility. Insurance deductibles, co-payments, and any co-insurance amounts are due at the time of services.

Print Name:_______________________________________

Signature:_________________________ Date:_________________

Release of Information:

I, the responsible party for the above child/children, authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to the party who accepts assignment of any claims. I authorize payment of medical benefits to Pediatric Associates of Southwest Missouri, LLC for any and all services rendered. This assignment will remain in effect until revoked by me in writing.

Signature:___________________________ Date_________________

I give Pediatric Associates of Southwest Missouri permission to email or text message appointment information.

Signature:__________________________ Date:________________

I have received a copy of the privacy policy notice for this office. ________(Initial)

Thank you for choosing Pediatric Associates of Southwest Missouri, LLC as your health care provider. We realize that patients have a larger part in paying for their healthcare with increased deductibles and co-payments or even in many instances, there is no insurance coverage at all. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Al patients must complete our registration form before seeing the doctor.

Full payment is due at time of service.

We accept **Cash, check, debit card, and all major credit cards.**

Regarding Self-Pay: We offer a 30% discount if paid in full same day.

Regarding Insurance: It is your responsibility to provide our office with correct insurance information at each visit and to update us on any plan or policy changes. This includes providing us with copies of your most current insurance card at each visit. Your insurance policy is a contract between you and your insurance company. We have agreed to accept the discounted rate from your plan however, ALL DEDUCTIBLES, CO-PAYS AND CO-INSURANCE amounts must be satisfied each and every visit. We will estimate balances to the best of our ability based on information provided by you and from the insurance verification. Since balances are estimated there may be a balance due from you after insurance has paid. <u>You are financially responsible for any amount not covered by your child's health insurance plan.</u> If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company.

Having more than one insurer DOES NOT mean that your services are covered at 100%. You are responsible for any balances.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Insufficient Funds: A $20.00 handling fee will be assessed to the patient for any check that is returned for insufficient funds. The responsible party will have ten days to take care of the insufficient check and the handling fee, by either credit card, cash, or money order. A check will not be accepted. If the balance has not been taken care of within the ten days the check will be turned over to a collection agency or the Prosecuting Attorney's office.

Adult Patients: Adult patients are responsible for full payment at time of service.

Minor Patients: The adult accompanying a minor and the parents/guardian is responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized by a supervisor.

Divorce Decrees: This office is NOT a party to your divorce decree.

Missed appointments: Unless cancelled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of up to a normal office visit. Please help us serve you better by keeping scheduled appointments. This charge is not a service and will not be filed to any insurance companies and is solely your responsibility.

Collection Agencies and Fees: A collection agency may take over delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of collection agency including attorney fees and court costs. Failure to meet your financial obligations could lead to dismissal from the practice.

I have read and understand the above stated financial policy.

Parent/Guardian Signature:___________________________________ Date:____________________

Printed Name:_____________________________________

Child's Name________________________ Date of Birth______________

Child's Name________________________ Date of Birth______________

Child's Name________________________ Date of Birth______________

Walk In Policy

Our primary concern is the safe, efficient delivery of medical care for *all of* our patients. We *do not* have any set "Walk in Hours".

We see our patients by appointment and do our best within the limits of circumstances that we can control, to see our patients on time. We feel that patients deserve our attention during the appointment time we have reserved for them. We do not allow walk in appointments, as it interferes with our ability to deliver safe medical care in a timely manner to all of our patients. To that end, we request that all patients call for an appointment time or receive an appointment time from the patient portal or Facebook message before coming to our office. **We DO have same day sick appointments available.**

There are very rare instances in which it is appropriate to come in before calling. A life threatening or potentially life-threatening situation is *not* one of these instances. **Anytime a parent feels that a life threatening medical condition is present, the appropriate course of action is to *immediately* call 911.** EMT's responding can assess the situation and provide emergency care, and transport the patient to an Emergency Room for further evaluation. It is not appropriate to come to the office in such situations. This will needlessly delay adequate medical evaluation and treatment and may put your child in a dangerous situation.

If you arrive at our office without an appointment, you will be charged an additional processing fee. This is a non-covered service, in which payment will be collected from the patient prior to being seen of an additional $25 not subject to insurance, deductibles or copays. We will have our staff assess your child and determine the urgency level of your child's illness. We will then triage your child to an appropriate appointment time. You may be asked to return at another time or day. If we feel that the most appropriate and safest course of action is to have your child evaluated and/or treated in an emergency room, we will refer you accordingly.

We ask that all our patients abide by this and all of our office policies. Chronically ignoring or failing to follow our office polices may result in our request that you find another pediatric group for your child's healthcare.

We value our patients and hope this policy allows all of our patients to feel that their appointment time is important to us!

Thank you!-Pediatric Associates Doctors, Management & Staff!

Signature_________________________ Date_______________

Printed Name____________________________

AUTHORIZATION FORM

Due to the variety of family situations it is important for the office to know our patient's home environment. To ensure the best possible care for all of our patients including maintaining confidentiality, it is the policy of this office that we will not release information to anyone over the telephone or in person other than the person who has signed our patient information sheet as being responsible of the child unless indicated below. If parents are divorced or separated we need to have the appropriate court documents in the child's records showing who has custody and or who is responsible for seeking medical care if it is so indicated in the court document. This office does not get involved in custody and or financial responsibility disputes. The person signing for responsibility for the child will be the person indicated as the once financially responsible for services rendered by our physicians. Any financial arrangements made between divorced/separated parents is to be handled between the parents.

Child's Name:_________________________________ DOB: ___/___/____

Child's Name:_________________________________ DOB: ___/___/____

Child's Name:_________________________________ DOB: ___/___/____

Child's Name:_________________________________ DOB: ___/___/____

Child/Children lives in the following environment:

☐ Both Parents living in the home ☐Parents divorced/separated ☐Single Parent Home

☐One parent and step-parent ☐ Lives with Grandparents ☐Foster Home

Permission to release appointment or account information to the following:

____ ___________________________________

Name Relationship Name Relationship

____ ___________________________________

Name Relationship Name Relationship

Permission to make appointments for and/or bring to their appointment on my behalf:

____ ___________________________________

Name Relationship Name Relationship

____ ___________________________________

Name Relationship Name Relationship

Parent Guardian Signature______________________________ Date_________________

Print Name:_______________________________