PATIENT INFORMATION PROFILE

Patient Name Date of Birth Sex

Patient Name Date of Birth Sex

Patient Name Date of Birth Sex

Address Home #

Cell #

Email Send reminders via: email phone

Father’s Name DOB

Address

Employed By Business #

Mother’s Name DOB

Address

Employed By Business #

Emergency Contact (not living with you)

Address

Home Phone # Cell #

Parent who is financially responsible for child’s account balance

Do you have insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No. *If yes, please provide us with a current copy of your card*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION. I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS. I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT. I understand that I am financially responsible for all charges for service rendered to my child/children, including the balance remaining after payment of insurance benefits.

Signature Date

**FINANCIAL POLICY**

1. All fees for self-pay patients are due at the time of service.

2. Our office will verify insurance prior to well child care visits. We will file and insurance claim with your insurer, however, verification of coverage does not identify specifically covered and non-covered items ad is not a guarantee of payment.

3. In the event a service we perform during the visit is not covered by your insurance, then full payment for this service is due within 60 days of receipt of said service.

4. All insurance cards must reflect the current insurance plan. Invalid information causing the claim to be returned will be subject to a $30 re-filing fee per claim filing.

5. We require 24 hours’ notice for cancellation of all appointments. Failure to do so or missing and appointment will result in a $25 cancellation/no show fee which is NOT covered by insurances. Reminder calls, emails, and texts are a courtesy provided by the office. Cancellation/no show fees are applicable even is a reminder is not received. Changing an appointment on the day of the visit will be subject to a $25 fee.

6. Please call the office if you will be late for your appointment. Patients will be worked back into the provider’s schedule at the provider’s discretion. Patients scheduled for well check visit may need to be rescheduled, and may be subject to the $25 late fee.

7. We do NOT file insurance for problems related to motor vehicle accidents or workman’s compensation. Full payment is due at the time of service.

8. A fee of $10 is required for forms filled out for sports physicals, pre-op clearance, and other administrative purposes. Or a one-time $25 annual fee can be paid for all forms requested.

9. Copies of medical records will be assessed a $5 fee for the whole chart.

10. There are no fees for call to the office during regular business hours. However, after hours calls that require a provider to call back may incur a $10 fee per call. These are NOT insurance covered charges. No fee is assessed if calls are handled by the insurance carrier’s medical advice line.

11. Walk in patients will be scheduled for the next available opening.

12. Add on patients (e.g. unscheduled patients whose parents request at the time of arrival that they be seen) will be seen by the provided when there is an available appointment.

I have read and understand the office policies stated above and agree to accept the responsibility as described above.

Signature of Patient or Legal Guardian Date

Patient’s Name(s)

**Patient Consent for Use and Disclosure of Protected Health Information (PHI)**

With my consent, Duluth Children’s Medicine, PC (DPL) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Refer to DPL’s Notice of Privacy Practices for a more complete description. I have a right to review the Notice of Privacy Practices prior to signing this consent. DPL reserves the right to revise its Notice of Privacy Practices at any time. A copy of a revised Notice of Privacy Practices may be obtained by sending a request to DPL at 3500 Duluth Park Ln, Ste 220, Duluth, GA 30096.

With my consent, DPL may call my home or other designated location and leave a message in person or on clearly identified voicemail in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to clinical care.

With my consent, DPL may mail to my home any items that assist the practice in carrying out TPO, such as patient statements.

I have the right to request that DPL restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If it does, it is bound by this agreement. By signing this form, I am consenting to DPL’s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures based on my prior consent. If I do not sign this consent, DPL may decline to provide treatment to me and my family.

Signature of Patient or Legal Guardian Date

Patient’s Name(s)

**PRESCRIPTION REFILL POLICY**

1. Routine Prescriptions will be refilled ONLY during our regular office hours.

2. Please allow 24 24 hours to refill any routine prescription refills.

3. Please be prepared to provide the medication name, strength (e.g. milligrams), amount, and timing. Also please provide the pharmacy information (phone number and location).

4. Please allow a minimum of 3 days for refill request of special prescriptions (e.g. stimulant medications for ADHD).

5. It is illegal for physicians to call in prescriptions in states where they are not licensed. Therefore, prescriptions will only be called into local pharmacies which then may have the discretion to transfer the prescription per their own policies.

I have read and understand the office policies stated above and agree to accept the responsibility as described above.

Signature of Patient or Legal Guardian Date

Patient’s Name(s)