Pediatric Physicians, Inc.

Patient Info – OVER 18

Patient Name: _____ Birth-date:_____ Gender: M F

Street: _____City: _____State: _____ Zip Code:_____

Email Address: _____ Phone: _____

Cell:_____ Social Security Number :_____

Demographic Information:

Ethnicity (circle one): Hispanic Not Hispanic Refuse to identify

Race: _____

Insurance Information:
(Please give your insurance card(s) to the receptionist)

Insurance Subscriber's Information

Name: _____ Phone: _____

Date of Birth: _____ Social Security #: _____

Mailing Address (if different from patient residential): _____

I certify the above information is true to the best of my knowledge.

_____ _____

PATIENT SIGNATURE **DATE**

Pediatric Physicians, Inc.

Patient Financial Policy

We are committed to providing you with the best possible pediatric care, and will work with you to meet any special needs you might have. However, that requires both the patient and physician understand what is expected of the other, medically and financially. The following information is an agreement between Pediatric Physicians, Inc. and Patient(s)/Responsible party named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services rendered.

Insurance participation

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. However, there are several points we wish to emphasize:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have any questions.
- You must bring your insurance card with you to every visit, and make us aware of any changes in coverage.
- If we do <u>not</u> participate with your insurance, you will likely have a higher out of pocket expense, so please be prepared.
- **You are expected to pay your copayment at each visit. If you ask us to bill you for this amount, or decline to pay on the date of service, we will have to reschedule your visit.**

Self-Pay Patients

If you do not have insurance, you will be asked to pay your balance at check-in for your visit.

Payment arrangements

If you need to arrange a payment plan, please ask for someone to assist you while you are in the office. Based on your total balance, we may offer limited payment terms.

No Show and Late Charges

If you are unable to keep your appointment, and do not provide at least 24 hours' notice of cancellation, your appointment is considered "LateCancel."
If you arrive more than 10 minutes late, your appointment is considered a "No-Show" and you must reschedule your appointment.
For "LateCancel" and "No-Show" appointments you will be subject to a $25 charge.
If you miss or are late for a consultation or ADHD appointment without notifying us 24 hours prior to your appointment, you will be charged a no-show fee of $50.

Responsible Party

Now that you are 18 or over, you are responsible for all your bills. You are responsible for paying copays before service and/or will be billed for any amounts applied to a deductible.

Past Due Accounts

If you balance is not paid in a timely manner, we reserve the right to forward your account to an outside collections agency or attorney.

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THESE POLICIES.

_____ _____

PATIENT SIGNATURE DATE

Pediatric Physicians, Inc.

CONSENT TO THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights and responsibilities with respect to your health care information.

The Notice of Privacy Practices provides more detailed information about how Pediatric Physicians, Inc. may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and Pediatric Physicians, Inc., encourages reading it in full. My signature below verifies that I have received the Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. Pediatric Physicians, Inc. must receive requests for any restriction disclosure in writing.

I hereby authorize Pediatric Physicians, Inc. to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment, and healthcare operations. This information may be delivered in person, via regular mail, telephone or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release Pediatric Physicians Inc. from any liability as a result of such transmission.

I have been informed and understand that Pediatric Physicians, Inc. will not bill third party payors (automobile/homeowners or other business insurances). I understand that all charges accrued by me must be submitted to my private health insurance (or paid for by me) and third party payors must settle privately with these individuals. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services given before the revocation was signed.

Check One:

☐ I authorize Payment of medical benefits directly to Pediatric Physicians, Inc. I understand I am financially responsible for any and all charges not covered by my insurance and guarantee payment on my account(s).

-OR-

☐ I agree to be responsible for all bills at time of service because one of the following is true:

- I have no insurance at this time
- I do not wish for Pediatric Physicians, Inc. to bill my insurance company.

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THESE POLICIES.

_____ _____

PATIENT SIGNATURE **DATE**

Pediatric Physicians, Inc.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

Patient Name: _____ Date of Birth: _____

Person/Organization Authorized to RECEIVE information:

__Name_____Phone number_____

_____

_____

_____

Practice/Organization/Person(s) SENDING information:

_____

_____

For the following dates of treatment:

_____

_____

For the purpose of:

— Further medical care
— Insurance/Billing
— Legal Reasons
— Other (please specify)

_____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed under this authorization. This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

Patient Signature: _____ Date: _____

Guardian/Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I understand that I may revoke this authorization at any time except to the extent that action based on the authorization has been taken. Cancellation of this authorization must be made in writing and sent to the address below:

Pediatric Physicians, Inc.
3643 Ridge Mill Dr.
Hilliard, OH 43026
Phone: 614-771-0200
Fax: 614-771-5267

This authorization is HIPAA compliant.
Eff. Sept 2015

Pediatric Physicians, Inc.

Pediatric Physicians, Inc. participates in a Health Information Exchange with Nationwide Children's Hospital. If you take part, you are authorizing the electronic exchange of medical information.

You have the right to ask that your medical record not be shared with a Health Information Exchange (HIE).

Please check Box 1 or 2:

☐ 1. I wish to take part in the Health Information Exchange.

☐ 2. I have NEVER been a part of the Health Information Exchange. I do not agree to my records being shared with other health care providers. – OR – I have been a part of the Health Information Exchange in the past; I now wish to WITHDRAW my consent.

_____ _____

Print Name of Patient Patient Date of Birth

_____ _____

Signature Date

See reverse for more information on the HIE

Pediatric Physicians, Inc.

Health Information Exchange ("HIE") is a safe way for health care providers to get the most up-to-date medical information about you. The HIE will allow Pediatric Physicians, Inc to access or share your health information with other healthcare providers. This may improve your overall care through the use of an electronic medical record. By signing this form, you are agreeing that your healthcare information, including your test results, lab reports, X-rays, medication lists or any other relevant electronic health information may be shared across participating health care providers.

You can withdraw your consent at any time. You do this by filling out the information below and submitting it to your healthcare provider. . If you withdraw your authorization, no new medical information may be shared with the HIE and the medical information already submitted to the HIE may not be used unless it has already been used in reliance on your authorization. You acknowledge that you read this form, were given the opportunity to ask questions and got answers you understood.

1. I understand that this authorization will expire one year from the date of my signature below.

2. I understand that I may shorten, extend, or revoke this authorization at any time by notifying the Privacy Officer at the address indicated below, in writing. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.

   Privacy Officer
   Pediatric Physicians, Inc
   3643 Ridge Mill Dr
   Hilliard, OH 43026.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

4. I understand that my refusal to sign this authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my protected health information is required for the provision of healthcare or to obtain payment for healthcare.

5. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as valid as the original.