PATIENT INFORMATION

Last Name: ______________________________ **First Name:** __________________
Date of Birth: ____________ **Sex:** ___________
Address: _____________________________________ **Apt#**_____ **City:** _______________
State/Zip: _________ **Cell number:** ____________________
Ethnicity: Hispanic/ Non-Hispanic
Race: Asian/ African American/ Native American/ White

Mother's/Guardian Name: _______________________ **Cell number:** __________________
Date of Birth: ___________ **Email:** _______________________@_______.com
Is the address the same as above? Yes or No?
If no, list: ____
Relation to Patient: _________________

Father's/Guardian Name: ______________ **Cell number:** __________________
Date of Birth: _______________ **Email:** ________________________@_______.com
Is the address the same as above? Yes or No?
If no, list: ____
Relation to Patient: _________________

INSURANCE INFORMATION

Primary Insurance: ______________________________________
ID#_____________________ **Group Number:** ______________
Policy Holder's Name: ______________________ **Policy Holder's Birth Date:** ______________
Patient Relations to Policy Holder: __________________ **SSN#** __________________

***Does this patient have secondary insurance? If yes, fill out below:**

Secondary insurance: ___________________________________
ID#_____________________ **Group Number:** ______________
Policy Holder's Name: ______________________ **Policy Holder's Birth Date:** ______________
Patient Relations to Policy Holder: __________________ **SSN#** ___________________

1.**Payment is required at the time of services rendered** unless other arrangements have been made in advance. This includes applicable deductible amounts, co-insurance and co-payments for participating insurance companies. Co-payments for children are due at time of service regardless of who brings the child in.

2.Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable thirty (30) days after the date of service. There will be a $25 charge for returned checks. If not paid within 30 days, Somers Pediatrics will begin various collection activities including but not limited by submitting the past account to collections. Patients who have not made a payment on their account in the past 30 days will be required to pay before they are seen in the office again, except in the case of an emergency.

3.**Self Payment**: if you have no insurance coverage. **We do not retro bill for self-pay visit even though you get insurance with retroactive dates.** However, we will gladly provide you with a copy of the super bills and your receipt.

4.**Missed/Sibling Appointments:** Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice. As a courtesy to all our patients, you may be asked to reschedule your appointment if you are more than 15 minutes late. A $25 no show fee will be charged after the second no show visit.

5.**Automobile accident patients:** We DO NOT treat automobile accident patients with any other insurance besides the insurance(health) that we have on file. Therefore, require payment at the time of service. We will not accept a letter of protection from an attorney as a guarantee of payment or third-party insurance payments.

6.Children of divorced parents: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individuals involved, without the inclusion of Somers Pediatrics

7.Your insurance company may require additional information to process your claim such as accident details, coordination of benefits or student status, If, after 10 days, your insurance company has not received this information from you, the balance will become your responsibility and you will receive a statement from us for payment in full.

8. **NEWBORN PARENT'S ONLY** You have 30 days to add newborn to your insurance policy or you will be responsible of the charges.

9 .We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance it is your responsibility to contact our office at (903)230-3311 within 30 days of receipt of the initial statement.

10.If your insurance company mistakenly sends you our payment, please forward the check immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.

11.There is a $25.00 charge for FMLA forms that need to be filled out and we require 3-5 business days for completion.

12.Please confirm with your primary health insurance that we are in network. In case we do not accept your insurance, or we are not the PCP, the patient will be responsible for the bill. Payment will be due at the time of visit.

13. Medical records transferred to patients and/or guardians will be charged a $25.00 fee.

14. After Hours In case of an emergency call 911. For non-urgent medical advice, contact your insurance company's nurse advice line. This number can be found on the back of your insurance card. If your insurance nurse line was not able to give you reassurance or unable to reach them, if still in need of medical advice, please call Somers Pediatrics office for after-hours instructions. Please be aware there may be a fee.

I, ____ do hereby affirm that I have read and understand the above policies. I hereby assign Somers Pediatrics all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment directly to my treating physician for medical services rendered to me or my dependents regardless of my insurance benefits, if any. I authorize Somers Pediatrics to release medical information that may be necessary to request reimbursement from insurance companies to whom they have submitted a claim. I give permission for Somers Pediatrics to treat and provide services needed to the patient understand that I am responsible for all medical fees during my treatment with Somers Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Name: __________________________________ Patient Date of Birth: _____________________

Signature of Parent or Guardian: __________________________ Date: ______________

Acknowledgement of Receipt of HIPPA Notice of Privacy Practice

I have received a copy and/ or read the "Notice of Privacy Practices," which explains how my medical information will be used and disclosed. A copy is available upon request.

In effort to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your child's privacy according to your wishes when it comes to your family and friends.

Please circle your response to the following:

May we send text or leave messages on a voicemail at home/ cell phone/ or work phone regarding an appointment, referrals, or test results? **Yes No N/A**

May we share your child's pertinent medial information with specialists that they may be seeing? **Yes No N/A**

May we communicate with you using our Updox portal? **Yes No N/A**

Treatment Authorization for Minors

We recognize that parents may not always be able to be present during treatment of their young child or teen.

I (parent/guardian): ____

Child's Name: ________________________________ Date of birth: _____/_____/_____

May be treated and discuss my child's medical needs with the following person

Name:

____

____

____

This authorization is valid until you notify us otherwise.

Parent Signature: ____________________________ Today's Date: ___________

Insurance Advance Beneficiary Notice

Waiver of Liability

Date of Service: ______________ Patient's Name: __________________________

Insurance will only pay for injections/ medications that are determined to be "reasonable and necessary" under insurance regulations. If your insurance company determines that an injection/ medication is "not reasonable and necessary" under your benefits, they will deny or partially pay for that injection. Likewise, they may pay less than the service cost our office. We are happy to file this injection/ medication for you, but we believe that, in your case, insurance is likely to deny payment for the following injections/ medications:

- Rocephin 250mg ($45)
- Rocephin 500mg ($50)
- Rocephin 750mg+ ($75)
- Decadron 1ml, 4ml, 6ml or 8ml+ ($40)
- Phenergan Gel 12.5mg or 25mg ($30)

Beneficiary Agreement:

I have been informed by Somers Pediatrics that my insurance will likely deny or partially pay for injections/ medications identified above. I agree to assume financial responsibility should that be the case.

____________________________________ ____________________________

Beneficiary Signature (or Legal Representative) Printed Name & Date