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

Primary Care Doctor: _____ **Phone Number:** _____

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: _____
Relations 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 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. **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.

5.**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.

6. 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.

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

8. 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)231-3144 within 30 days of receipt of the initial statement.

9. 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.

10. **FMLA:** Our clinic will not fill out FMLA forms. We ask that you follow up with your child's primary care doctor.

11. Please confirm with your primary health insurance that we are in network prior to coming into the clinic. Anything denied by insurance due to being out of network will be your responsibility.

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

13. **Somers Pediatrics Urgent Care does not offer After-Hours service.** 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 could not give you reassurance or unable to reach them, if still in need of medical advice, please contact your child's primary care doctor to see if that office offers After-Hours.

14. **Right to Refuse or End Care**
At Somers Urgent Care, we strive to care for every patient with respect and professionalism. However, we reserve the right to refuse service or end the provider-patient relationship if a patient or parent is repeatedly noncompliant, abusive, threatening, disrespectful, or fails to meet financial responsibilities. Except in emergencies, we will provide notice and resources to help you transfer care to another provider if needed.

I, _____ do hereby affirm that I have read and understand the above policies. I hereby assign Somers Pediatrics Urgent Care 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 Urgent Care 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 Urgent Care to treat and provide services needed to the patient. I understand that I am responsible for all medical fees during my treatment with Somers Pediatrics Urgent Care. 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.

To comply with the Health Information Privacy Act (HIPAA), 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 or No**

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

May we communicate with you using our portal? **Yes or No**

May we opt your child into the **Carequality framework and/or National Record Locator Service (NRLS)** through eClinicalWorks (eCW) to securely obtain their medical records, medication history, and other relevant health information from other healthcare providers who use the same systems?

☐ **Yes, I consent**
☐ **No, I do not consent**

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: _____/_____/_____

To be accompanied, treated, and have their medical needs discussed with the following person(s):

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 Urgent Care 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

Authorization for Release and Exchange of Medical Records

I, **(patient/parent/guardian name)**: _____

Authorize **Somers Pediatrics Urgent Care** to:

- **Release medical records** to my child's Primary Care Provider and/or Hospital.
- **Request medical records** from my child's Primary Care Provider and/or Hospital.

Patient Name: _____

Date of Birth: _____ / _____ / _____

Primary Care Provider: _____

Address / Fax / Phone (if known): _____

Hospitals Include:

- Longview Regional Medical Center
- Christus Good Shepherd
- Hospitality ER
- Other: _____

_____(initial) This authorization will remain valid until further notice, unless revoked in writing by the parent/guardian. ** **Do not sign this form if you do not want Somers Pediatrics Urgent Care to release or request your/your child's medical records.**

Signature (Patient or Parent/Guardian if minor): _____
Date: _____ / _____ / _____
Relationship to Patient: _____