Attention! Please Read!

- IF YOUR CHILD HAS A CHANGE IN INSURANCE, WE NEED THAT INFORMATION PROVIDED IMMEDIATELY.

- YOU MUST PROVIDE ALL INSURANCE INFORMATION AT THE TIME OF THE VISIT. FAILURE TO DO SO MAY RESULT IN YOUR RESPONSIBILITY FOR THAT VISIT.

- PLEASE PROVIDE US WITH YOUR CHILD'S INSURANCE CARD AT EVERY VISIT.

- IF YOU HAVE BCBS, PLEASE NOTIFY THE FRONT DESK AND THE NURSE IF YOUR WELLNESS VISIT IS **HEALTHY YOU OR PREVENTATIVE WELLNESS.**

- FINALLY, IF YOU HAVE A CHANGE IN YOUR ADDRESS OR PHONE NUMBER, WE NEED THAT INFORMATION PROVIDED IMMEDIATELY. WE WILL ASK FOR AN UPDATE ON DEMOGRAPHICS EVERY YEAR.

STARKVILLE PEDIATRIC CLINIC PATIENT REGISTRATION

PLEASE PRINT AND
PLEASE PROVIDE A COPY OF YOUR CHILD'S INSURANCE CARD

CHILD'S NAME: ______________________________
LAST NAME FIRST MIDDLE (NICKNAME)

DATE OF BIRTH: ______________ RACE: ______________ SEX: ______________
(M/F)

PLACE OF BIRTH/HOSPITAL: ______________ CHILD'S SOCIAL SECURITY NUMBER: ______________

MOTHER'S NAME: ______________________________ MOTHER'S DATE OF BIRTH: ______________
LAST NAME FIRST MIDDLE

MOTHER'S SOCIAL SECURITY NUMBER: ______________

PHYSICAL ADDRESS: ______________ APT/LOT#: ________ COUNTY: ______________

MAILING ADDRESS: ______________________________

CITY: ______________ STATE: ________ ZIP: ______________

EMPLOYER: ______________ EMAIL: ______________

CELL PHONE & **CELL PHONE CARRIER**: ______________ ______________

HOME PHONE: ______________ WORK PHONE: ______________

***IT IS VERY IMPORTANT TO PROVIDE US WITH A WORKING PHONE SO THAT WE MAY REACH YOU TO PROVIDE MEDICAL INFORMATION REGARDING YOUR CHILD(REN).**

FATHER'S NAME: ______________________________ FATHER'S DATE OF BIRTH: ______________
LAST NAME FIRST MIDDLE

FATHER'S SOCIAL SECURITY NUMBER: ______________

PHYSICAL ADDRESS: ______________ APT/LOT#: ________ COUNTY: ______________

MAILING ADDRESS: ______________________________

CITY: ______________ STATE: ________ ZIP: ______________

EMPLOYER: ______________ EMAIL: ______________

CELL PHONE & **CELL PHONE CARRIER**: ______________ ______________

HOME PHONE: ______________ WORK PHONE: ______________

***IT IS VERY IMPORTANT TO PROVIDE US WITH A WORKING PHONE SO THAT WE MAY REACH YOU TO PROVIDE MEDICAL INFORMATION REGARDING YOUR CHILD(REN).**

EMERGENCY CONTACT (other than parent): ______________________________ PH: ______________
NAME RELATIONSHIP

SIGNATURE OF PARENT/GUARDIAN: ______________________________ DATE: ______________

STARKVILLE PEDIATRIC CLINIC PATIENT REGISTRATION

Insurance Policy Acknowledgement
PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

CHILD INSURED NAME: ____________________

CHILD DATE OF BIRTH: __________ CHILD SOCIAL SECURITY #:__________

CHILD GENDER: __________

PRIMARY INSURANCE COMPANY NAME: ____________________

PRIMARY INSURANCE HOLDER NAME **(IF NOT PATIENT)**: __________

DATE OF BIRTH OF INSURANCE HOLDER: ____________________

SOCIAL SECURITY # OF INSURANCE HOLDER: ____________________

EMPLOYER OF INSURANCE HOLDER: ____________________

EFFECTIVE COVERAGE DATE: ____________________

POLICY ID#: __________ GROUP ID#: __________

BENEFIT ID (CO-PAY/DEDUCTIBLE): ____________________

PRIMARY CARE PHYSICIAN (PCP): ____________________
(IF APPLICABLE)

Complete only if child has a secondary insurance

SECONDARY INSURANCE NAME: ____________________

EFFECTIVE COVERAGE DATE: ____________________

POLICY ID#: __________ GROUP ID#: __________

BENEFIT ID (CO-PAY/DEDUCTIBLE): ____________________

I hereby authorize payment of insurance benefits directly to Starkville Pediatric Clinic. I understand I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf of my dependents. I authorize the above noted provider of services in this office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company, and I take full responsibility for financial obligations incurred. I understand I am directly responsible for payment of any billing fees, court costs, and/or collection fees added to my account in the pursuit of collecting monies owed to Starkville Pediatric Clinic. I authorize the performance of whatever procedures necessary in executing the treatment of the above-named patient.

____________________ ____________________
Signature of Parent /Guardian Date

Consent to Immunize Policy

As the parent or guardian of ________________________, I understand that Starkville Pediatric Clinic will not accept patients who are not immunized or do not have plans to immunize. I understand and accept that if I have private insurance, I may discuss an alternative immunization schedule for my child with my provider, and if this alternative schedule is approved, it is my responsibility as the parent or guardian to provide the alternative schedule. I also understand and accept that my child must begin immunizations no later than 6 months old. If my child has Medicaid insurance, I understand and accept that I may not follow an alternative schedule and must adhere to immunize my child according to the signed contract with the Mississippi Division of Medicaid and the Mississippi Department of Health.

Therefore, I hereby authorize and request the physicians or their staff to immunize my child according to the approved schedule of the American Academy of Pediatrics. I will receive a copy of the vaccine information sheet for each immunization my child will receive, and I will have a chance to ask questions surrounding the immunizations that will be given.

I agree to promptly inform the physicians or their staff of any significant symptoms or side effects that I believe to be associated with past, present, or future immunizations. This consent shall apply to the following immunization:

Required	**Optional**
Diptheria, Whooping Cough, Tetanus	Human Papillomavirus Vaccine
Haemophilus B Conjugate	Hepatitis A
Injectable Polio	Meningococcal Conjugate
Measles, Mumps, Rubella	Meningococcal Group B
Hepatitis B	Influenza
Varicella	
Pneumococcal Conujugate	
Pneumococcal	
Rotavirus	

___I agree to vaccinate my child according to the guidelines endorsed by the American Academy of Pediatrics.
___I plan to discuss an alternative immunization schedule for my child with my provider, and if this alternative schedule is approved, it is my responsibility as the parent or guardian to provide the alternative schedule. I also understand and accept that my child must begin immunizations no later than 6 months old.
___I refuse to vaccinate my child and understand that I will need to find a new clinic for our pediatric services.

________________________________ ________________________

Parent or Guardian Signature Date

I do ____ or do not ____ authorize the physicians or their staff to release immunization information to the school system or daycare center, if requested by those organizations.

________________________________ ________________________

Parent or Guardian Signature Date

STARKVILLE PEDIATRIC CLINIC PATIENT REGISTRATION

Authorization for Medical Treatment of Minors

I, ______________________________, parent or legal guardian of:

______________________________ ______________________________
Child's Full Name Date of Birth

do hereby authorize the following individuals (must be over the age of 18) to schedule appointments and/or accompany my children to medical appointments and sign for treatment to include immunizations. Please list anyone other than the child(ren)'s biological mother or biological father who may be accompanying the child(ren) to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc. I understand that only my child(ren)'s biological mother and father and those listed below will have the authority to authorize treatment.

Authorized individuals include (please print name and relationship to child):

______________________________ ______________________________

______________________________ ______________________________

In the case of an emergency, unlisted individuals may obtain treatment for your child(ren). In that case, an attempt to contact you by phone will be made. This authorization will remain in effect until those designated above have their consent revoked in writing.

***Please inform the above listed individuals to bring photo ID to appointments**

Authorization to Leave Messages on Voice Mail/Machines

I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

__________Yes, please leave me a message

__________No, don't leave any specific messages

I have read the information above and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Starkville Pediatric Clinic of any changes in my health status, my child(ren)'s health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

______________________________ ______________________________
Signature Date

STARKVILLE PEDIATRIC CLINIC PATIENT REGISTRATION

Divorced Parents or Step-Parents Policy

As your child's pediatrician, our goal is to provide the best pediatric care for your child. However, please be aware that our office is not party to your divorce agreement and we cannot and will not be responsible for administering any of its terms.

We will ask that the parent/step-parent bringing the child into the office pay the co-payment, deposit, and/or outstanding balance at the time of the visit. We will not bill or split bill the other parent at any time. Statements go to one parent, usually the one with primary custody, and they are free to forward copies on to the other parent. Per Mississippi law, both parents are equally responsible for a child's medical bills. If your divorce documents state otherwise, that is an issue to take up with your attorney. We ask that payment be made to us, and you or your attorney can seek reimbursement from the other parent. If an account becomes delinquent and goes to collections, the collection agency will pursue both parents.

Before we can allow a step-parent to bring a child in for treatment, we must have on file, in writing, a "consent to treat" from either parent. This indicates whom they authorize to bring the child in for medical treatment. Both parents can submit a listing. If the parents disagree on this issue, this must be addressed with your attorney. We will not override a parent's rights unless court documents are received. Both parents have a right to schedule appointments for their child. We will not call the other parent and inform them of said appointment, nor will we call them to advise them of what happened during said appointment. That communication is left up to the parents.

If, after speaking with the parent/person who brought the child in for a visit; you still have questions regarding your child's care, we ask that you please call and leave a message. The provider will call you back. As your child's healthcare provider, we will not be used as a vehicle of communication between divorced parents, therefore we need you to communicate regarding your child.

Both parents have equal rights to the child's medical information so long as the parental rights have not been severed. If parental rights have been terminated for either one or both parties, we will require a copy of the court documentation to that affect. Both the custodial and non-custodial parent have a right to medical information on their child. Note: this parental right is restricted to access of the child's medical information and does not include access to the address, telephone number, or any information regarding the other parent.

The best scenario is for both parents and any step-parent involved to communicate openly with one another and actively participate in the healthcare and treatment of the child. This open communication will benefit all parties, especially the child(ren).

____________________________ ____________________________

Signature Date

STARKVILLE PEDIATRIC CLINIC PATIENT REGISTRATION

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Facility named at the top of this page. I understand further that the Medical Facility and its business associates (including its billing company) may use or disclose my health information in communications with third parties who are involved in or indicate that they are responsible for payment for my healthcare services. I understand that such third parties might include persons who are the policy holders of any policy of insurance covering me. I acknowledge that I am entitled to prevent these communications by objecting to them, and by my signature below, indicate that I DO NOT OBJECT to such communications.

Print Name of Patient______________________________________Date: _________________

Patient's Date of Birth:_____________________

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative:______________________________Date: ________________

Relationship of Representative (parent, guardian, etc.): _______________________________

Signature of Personal Representative: ____

OPTIONAL DESIGNATION OF PERSONS TO WHOM WE MAY DISCLOSE YOUR RECORDS IN YOUR ABSENCE:

1. ____
2. ____

(You may also call us or personally inform us at any time of persons to whom we may disclose your records.)

For Facility Use Only:

Signature of Facility Employee Date

Updated 1/13

STARKVILLE PEDIATRIC CLINIC PATIENT REGISTRATION

Financial Policy Acknowledgement

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. **IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE.** Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

Starkville Pediatric Clinic has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with *your* insurance company, and which provider is listed as your primary care physician. Any financial portion that is the "member's responsibility" such as a co-pay, deductible or a non-covered percentage will be collected ***at the time of service.*** _______ (initial) Remember, your insurance coverage is a contract between you and your insurance company. Starkville Pediatric Clinic is not responsible for services denied by your insurance company. _______ (initial) Further, should court or collection actions be necessary to secure payment, any and all fees will be charged to the Guarantor on the account. _______ (initial)

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

HMO INSURANCE PLANS: All co-pays must be paid at each visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

NON-CONTRACTED INSURANCE PLANS: If we are not contracted with your insurance company you will be asked to pay in full at the time of service. We can supply you with a billing copy to attach to a claim form (should be supplied by your insurance broker or Human Resources department) to send to your insurance company to request that payment be sent to you.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

MEDICAID: We accept Medicaid for newborn hospital follow up exams. If you do not have the baby's Medicaid information available at the time of the exam we will pend the charge for up to 30 days, to allow time for the Medicaid number to be assigned. If you do not provide us with the Medicaid billing information within 30 days, we will change the account to "Self Pay-No Insurance". At that point you are required to make payment within 30 days or you will be subject to collection efforts.

DIVORCE DECREE: We are not a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, MasterCard, Discover, and personal checks. Any outstanding balances are due within 30 days of the statement. If you experience circumstances beyond your control, please call our office immediately after receiving the first statement, and we will be happy to make payment arrangements. All balances reaching 90 days past due may be sent to a collection agency and/or submitted for legal action. Should your account be sent to a collection agency or submitted for legal action, you will be financially responsible for all collection fees, legal fees, or court costs that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a returned check fee (the amount of which is based on the amount of the returned check), in addition to the original amount of the check. You will have 15 days to clear the outstanding check and future check writing privileges may be jeopardized. If you do not pay the check plus the return fee in the specified time, a complaint will be filed with the State's Attorney Office and we will be unable to continue a doctor/patient relationship.

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel with a minimum of one hours notice in order for another child to be scheduled. If you do not cancel by the deadline, a $25 missed appointment fee will be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment. **EXCEPTION: If you are a Medicaid recipient, please understand that we are unable to charge you for missed appointments. Therefore, in an effort to increase office efficiency, if you accrue more than 3 missed appointments with our office, we will be unable to continue caring for your child and you will be asked to find another doctor to care for your child.**

I authorize medical care and accept the financial responsibility for my child(ren), my step children, and/or the child(ren) that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims. I authorize the download of my child's medication history and RX benefits into his/her account from an RX clearinghouse.

I have read and fully understand the financial policies of Starkville Pediatric Clinic and agree to the terms. I also understand that the terms of these financial policies may be amended by the Practice at any time without prior notification.

______________________________   ______________________
Parent/Guardian/Personal Representative   Date