PARTNERS IN PEDIATRICS, LLC

PATIENT REGISTRATION FORM

*****PLEASE PRINT & PROVIDE ALL INFORMATION BELOW*****

PRIMARY PHYSICIAN

Wood Brannon Blakeney Diebel Mukkamala McNally Speight Hooper Schull Troy Scott Rutland

PATIENT INFORMATION

First *Middle* *Last* *Preferred Name* *Social Security #*

M F

Date of Birth *Sex* *Race* *Ethnicity* *Religion* *Preferred Language*

ALLERGIES: **Does your child have any known Drug/other Allergies?** _____

Do we see any other children in your family? Yes No List Each: _____

FAMILY INFORMATION

Child lives with: Parents Mother Father Grandparent Foster Parent Other: _____

Primary Family Email Address: _____ ***(Best Email for Reminders, Notices and Information)***

Primary Family Phone Number _____ ***(Best Phone Number for Reminders)***

Parent/Legal Guardian Name

First *Middle* *Last*

Relationship to Child: _____

Street Address *City,State,Zip*

Home Phone *Cell Phone*

Authorization to Contact by Cell Phone and/or Text Yes No

DOB *Social Security #*

Employer *Work #*

Drivers License # *State*

Parent/Legal Guardian Name

First *Middle* *Last*

Relationship to Child: _____

Street Address *City,State,Zip*

Home Phone *Cell Phone*

Authorization to Contact by Cell Phone and/or Text Yes No

DOB *Social Security #*

Employer *Work #*

Drivers License # *State*

Parent/Guardian Status **Single Married Divorced Widowed If divorced, who has legal custody:** _____

Legal Documents Provided: Yes No - If yes specify: _____ **Other:** _____

EMERGENCY CONTACT & AUTHORIZED PERSON(S)

List Person(s) to contact in case of an emergency other than parent/legal guardian and/or person(s) authorized to bring child to visits and have access to "ALL" patient medical and financial information.

Name/Phone Number: _____ **Relationship to Patient:** _____

Name/Phone Number: _____ **Relationship to Patient:** _____

Name/Phone Number: _____ **Relationship to Patient:** _____

Name/Phone Number: _____ **Relationship to Patient:** _____

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE

PRIMARY INSURANCE

Insurance Company

Primary Insurance Holder Name *DOB*

Member ID # *Group ID #*

Employer

SECONDARY INSURANCE

Insurance Company

Primary Insurance Holder Name *DOB*

Member ID # *Group ID #*

Employer

CONTINUED

PARTNERS IN PEDIATRICS, LLC

PATIENT REGISTRATION FORM CONTINUED

POLICIES & PROCEDURES

PLEASE READ CAREFULLY, INITIAL AND SIGN AUTHORIZATION BELOW

INSURANCE: Partners in Pediatrics, LLC accepts assignment of insurance benefits from most major insurance companies for payment of services on your behalf. It remains your responsibility to verify coverage with our physicians and your specific policy before treatment. Our business office is ready to assist you with your coverage questions.

Initial ____

CO-PAY: Your insurance policy and the agreement between your physician and the insurance company requires that we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay is not made at the time of service, then an additional $10.00 service charge is added to your account.

Initial ____

SELF-PAY: If your child does not have medical coverage or is out of the network, then you must see the business office before treatment. You are responsible for all charges incurred at the time of service. The business office will assist you with the amount due. You may receive a copy of your itemized billing statement for insurance or tax purposes.

Initial ____

NO SHOW: As a courtesy, we will provide reminders for your appointment. If you are unable to make your scheduled time, then you must notify our office 24 hours prior to that time. Missing three (3) scheduled appointments will result in dismissal from the practice.

Initial ____

HOSPITALIZATION: In the event of hospitalization, we will file the hospital charges incurred for the physician treating your child. If newborn patient charges are incurred, then it is your responsibility to add the newborn to your policy or another acceptable policy within 30 days of date of birth. If no insurance is acquired, then you will be responsible for all newborn hospital charges and all subsequent office visit charges if any.

Initial ____

POLICY AGREEMENTS: I acknowledge that I have read the full **Financial Policy** and **Office Policy** available in the New Patient Registration Packet and at mykidsdr.com, and I agree to the terms set forth therein.

Initial ____

AGREEMENT TO PAY: In case of default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees, attorney's fees, (33.33%) court costs and all other expenses related to the collection of the outstanding balance will be paid by the undersigned. You agree, in order to service your account or to collect monies you may owe, Partners in Pediatrics, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.

Initial ____

PRIVACY: I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Information Portability & Accountability Act of 1996 (HIPAA) and have been offered a copy of it.

Initial ____

AUTHORIZATION AND CONSENT FOR TREATMENT

I, the undersigned, consent to the treatment necessary for the care of the below listed patient. I hereby authorize release of any or all medical records to the referring physician my insurance carries or those involved in payment of my account. Further, I acknowledge full financial responsibility for any services rendered by Partners in Pediatrics, LLC, and understand that payment of charges incurred in this office is due at the time of service. I consent for the charges to be filed electronically and/or via paper claims (I500 and UB04) by signing this consent form. I also understand that charges not covered by the insurance remain my responsibility and assign insurance benefits to PIP. In the event an account is not paid within 90 days, the undersigned agrees to pay all cost of collection including attorney's fees and hereby waives all right of exemption under the constitution of the State of Alabama.

I, as the parent, guardian, or legal personal representative, give my permission to Partners in Pediatrics, LLC and their employees to provide medical care to my child. I realize I am responsible for accompanying my child or children while on the premises. According to HIPAA law, I shall update this information at least annually or sooner if any change occurs.

_____ _____

Signature of Parent or Responsible Party ***Date***

_____ _____

Patient Printed Name ***Patient Date of Birth***

OFFICE USE ONLY

Print or email this PDF to forms@mypartnersinpediatrics.net. Please attach a copy of your DL and Insurance card to the email.

Partners in Pediatrics, LLC

FINANCIAL POLICY

PRIVACY: A copy of our Notice of Privacy Practices is available and given to all patients in accordance with The Health Portability & Accountability act of 1996 (HIPAA). (Included with original Registration material)

INSURANCE CARD: *We must have a copy of your current health insurance card on file and please be prepared to show your insurance card at each visit. Insurance eligibility must be verified prior to seeing the doctor or you will be required to pay at the time of service. If there is a change in your insurance coverage, please notify us promptly. Some insurance companies have time limits on when claims need to be submitted. If we do not have the correct information, we cannot file the claim in a timely manner.*

INSURANCE: *Our office accepts assignment of insurance benefits from most major insurance companies for payment of services rendered. The responsible party must verify specific coverage with our physicians and the specific policy before treatment. Refer to our Billing & Insurance Policy for a list of insurance plans we have contracted with and payment methods accepted. Our business office will assist you with coverage questions related to your insurance plan.*

CO-PAYMENTS: *Our physicians are contractually obligated per your insurance company to collect a co-payment at the time of service. Your insurance policy and the agreement between your physician and the insurance company requires we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay cannot be made at the time of service your appointment can be rescheduled and an additional $10.00 service charge will be added to your account balance.*

SELF-PAY: *If there is no medical coverage at the time of service or our physician is out of network, then the responsible party is liable for all charges incurred at the time of service. The business office will assist with the amount due and provide a copy of any itemized billing statement for insurance or tax purposes.*

PRIMARY CARE PHYSICIAN: *We will ask you at our front desk to select a primary care physician, but it is your responsibility to notify your insurance company within 30 days that your child's primary care physician is at Partners in Pediatrics, LLC.*

HOSPITALIZATION: *In the event of hospitalization, our office will file for the hospital services provided by the physician treating the patient. If newborn patient charges are incurred, then it is the parent's responsibility to add the newborn to the policy or another acceptable policy within 30 days of the date of birth. If no insurance is acquired, then the parents or responsible party will be liable for all newborn hospital charges and any subsequent office visit charges incurred until insurance is in force.*

***BALANCES & DEDUCTIBLES*:** *In the terms of our contracts with health insurance companies, we are responsible for billing you any portion of your treatment that your health insurance carrier does not pay. You are responsible for paying this portion of your bill. All balances are due at time of service or upon receipt of your financial statement. Failure to pay could result in collection activity or dismissal from the practice. Your child's appointment may be rescheduled if you are not prepared to pay any past due balances or deductibles at the time of service.* In the event of a returned check for insufficient funds, your account will be charged $35. Refunds will be issues on accounts with a credit of $50 or more. Any account with credits less than $50 will have funds held for future visits unless authorized by the business office.

PAYMENT PLANS: *We understand at times families may experience financial hardship and do offer payment plans. Your first payment will be due upon signing a written agreement. Payments are based on the amount owed. No payment plan will be given to amounts less than $100. If your payment plan is in default, the balance will be due in full. Failure to pay may result in collection activity and/or dismissal from the practice.*

NO RESPONSE CLAIMS: *If your insurance company does not respond to the claim within ninety (90) days from the date of the claim, you are responsible for the payment of the bill.*

MEDICAID INSURANCE: *We accept Alabama Medicaid insurance by state assignment only. Children on Medicaid are limited to 14 visits per calendar year and 1 well visit per calendar year. Once you reach 14 visits then you are responsible for payment in full. ER visits for routine health problems may count as a doctor visit. Using one doctor and one drug store is best for your child's health.*

AGREEMENT TO PAY: *The parents or responsible party agrees to pay any account balance. In case of a default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees, attorney's fees, (33.33%) court costs and all other expenses related to the collection of the outstanding balance will be paid by the undersigned. You agree, in order to service your account or to collect any amount owed, Partners in Pediatrics, LLC and/or its agents may make contact by telephone at any telephone number associated with the account, including wireless telephone numbers, which could result in charges. We may also make contact by sending text messages or emails, using any email address provide for our use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.*

Partners in Pediatrics, LLC

GENERAL OFFICE POLICIES

Registration/Demographic Information: At least annually we are required to obtain updated information from each patient which authorizing our clinicians to provide continuous medical services to that patient. Our policy is that all new patients must complete patient information forms prior to being seen and established patients must update the information sheet every twelve (12) months or whenever there is a change.

Privacy: A copy of our Notice of Privacy Practices is available to all patients in accordance with HIPAA (Health Portability & Accountability Act of 1996). This documentation can be found on our website and in our patient registration packet.

Minor Patients: A parent or legal guardian must accompany any minors to receive medical care services at our practice. Written authorization allowing other persons to accompany patients to office visits must be provided on the registration form. We may deny care unless this policy is followed.

Adolescent Consent: Adolescents age 16 years and older may be requested to sign a release of information form. Some exceptions are made for emergencies as listed under Ala. Code. Sec. 22-8-1, Ala. Code Sec. 22-8-3, Ala. Code Sec. 22-8-4 and Ala. Code Sec. 22-8-6.

Transition Age: It is our recommendation that once adolescent patients reach age 19 and/or has graduated from high school he/she should find an internal or family medicine provider that can give adult medical care. You may request us to recommend an adult physician by calling our office.

Patient Portal: Our front office staff will assist patients with Patient Portal access and instructions. Each patient is given a unique login per child. This system is to give our patients a convenient way to access information such as labs, office visit information, and a way to send messages to your care team.

Call-backs: If you leave a message and expect a call-back, be sure to speak clearly, leaving a detailed message with the patient name, reason for the call, person calling and best callback number. Your call will be returned promptly by the appropriate team member.

Prescription Refills: Our prescription refill line is available during normal business hours Monday-Friday. Please allow three (3) business days for processing. Medications for ADD/ADHD, asthma and some other medications may not be refilled if your child has not been in the office for a medication management visit within the last six (6) months.

Referrals: Most managed care insurance plans require referrals from your primary care physician before your child can be seen by a participating specialist. It is necessary to ask parents to provide us at least three (3) business days for a referral to be completed and forwarded to the specialist. Our Referral Specialists are available during normal business hours Monday-Friday.

Nurse Line: Our nurse line is available during normal business hours Monday-Friday. This service is for questions you may have about your child's health and for advice regarding minor medical issues. This line is not intended for routine questions that can be asked during your visits to our office or to schedule appointments.

Appointments: A parent or legal guardian must be present for the initial visit to receive medical care at our practice. Please be sure to be prepared for all appointments by having your insurance card and filling out any necessary forms prior to seeing the doctor. Same-day appointments are available with sick appointments given first priority. Appointments can be scheduled at any of our offices by calling the main office line during normal business hours Monday-Friday.

Late or Missed/No Show Appointments: If you are unable to make your scheduled appointment, you must notify our office by 24 hours prior to appointment. Missing three (3) scheduled appointments in a year will result in dismissal from the practice. If you are running late you should immediately call our office to determine if we must reschedule. Patients running 30 minutes late for an appointment regardless of reason will either be asked to reschedule and/or may be worked in when a physician is available.

After-Hours: Our physicians are on-call after normal business hours through our on-call system by calling the office line. The on-call system will route your message to the nurse or physician on-call. This service is for urgent problems that can't wait until the next business day (no medical refills or routine questions, please!).

Emergencies: We recommend all parents learn CPR and keep emergency numbers handy. Call 911 for life-threatening emergencies or go to your nearest emergency room. Ask the ER staff to contact our office upon arrival. For poisoning, call The Regional Poison Control Center Children's Hospital at 1-800-222-1222 for poison advice for all ages.

Medical & Immunization Records: Medical records must be requested in writing and signed by a parent or guardian. Please speak the billing office for questions regarding fees for records. If an immunization record is requested by fax, there MUST be written consent to release this information. All records can be picked up at the office.

Dismissal of Patient-Physician Relationship: Physicians may terminate a relationship with a patient at any time. If this happens, the patient will receive a written notice explaining the reason for dismissal. The physician will provide the patient access for 30 days of service for urgent medical matters only. Our practice reserves this action for any situation that constitutes a breakdown in the patient-provider relationship. This includes but is not limited to patients who demonstrate a lack of respect for their medical services and the practice by missing appointments repeatedly, disregarding the practice's stated policies, or behaving in a way that is deceptive, disrespectful, or dishonest.

Partners in Pediatrics, LLC

HIPAA Notice of Privacy Practices

(Effective Date - September 2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Partners in Pediatrics, LLC, 8160 Seaton Place, Montgomery, AL 36116:

- **Right of Access to Inspect or Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Partners in Pediatrics, LLC, 8160 Seaton Place, Montgomery, AL 36116 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**