SUMMIT PEDIATRICS

PATIENT INFORMATION – PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT

First Name:________________ Last Name:________________ MI:________

DOB:____________ Sex: M___ F___ Preferred Language:____________ Lives with: ___Mom ___Dad ___Both ___Other

*Ethnicity: ___Hispanic ___Non-Hispanic *Race: ___White ___Hawaiian-Pacific Islander ___Black ___American Indian ___Alaskan Native ___Asian

First Name:________________ Last Name:________________ MI:________

DOB:____________ Sex: M___ F___ Preferred Language:____________ Lives with: ___Mom ___Dad ___Both ___Other

*Ethnicity: ___Hispanic ___Non-Hispanic *Race: ___White ___Hawaiian-Pacific Islander ___Black ___American Indian ___Alaskan Native ___Asian

First Name:________________ Last Name:________________ MI:________

DOB:____________ Sex: M___ F___ Preferred Language:____________ Lives with: ___Mom ___Dad ___Both ___Other

*Ethnicity: ___Hispanic ___Non-Hispanic *Race: ___White ___Hawaiian-Pacific Islander ___Black ___American Indian ___Alaskan Native ___Asian

First Name:________________ Last Name:________________ MI:________

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First Name:________________ Last Name:________________ MI:________

DOB:____________ Sex: M___ F___ Preferred Language:____________ Lives with: ___Mom ___Dad ___Both ___Other

*Ethnicity: ___Hispanic ___Non-Hispanic *Race: ___White ___Hawaiian-Pacific Islander ___Black ___American Indian ___Alaskan Native ___Asian

(*) Indicates optional information (Meaningful Use Data)

PARENT/GUARDIAN INFORMATION

Full Name:________________________ Relationship: ___Mother ___Father ___Other:________

Address:________________________ City:____________ State:________ Zip:________

Phone: Cell:____________ Home:____________ Email:________________

Full Name:________________________ Relationship: ___Mother ___Father ___Other:________

Address:________________________ City:____________ State:________ Zip:________

Phone: Cell:____________ Home:____________ Email:________________

Full Name:________________________ Relationship: ___Mother ___Father ___Other:________

Address:________________________ City:____________ State:________ Zip:________

Phone: Cell:____________ Home:____________ Email:________________

Full Name:________________________ Relationship: ___Mother ___Father ___Other:________

Address:________________________ City:____________ State:________ Zip:________

Phone: Cell:____________ Home:____________ Email:________________

INSURANCE INFORMATION

Insurance:____________________________________

ID#:____________________________________

Group #:____________________________________

Policy Holder:____________________________________

Policy Holder DOB:______________________ Sex: M___ F___

Relationship to Patient: ___Self ___Mom ___Dad ___Other:__________

Insurance:____________________________________

ID#:____________________________________

Group #:____________________________________

Policy Holder:____________________________________

Policy Holder DOB:______________________ Sex: M___ F___

Relationship to Patient: ___Self ___Mom ___Dad ___Other:__________

EMERGENCY CONTACT *(someone not living in the same household)*

Name:____ Relation to Patient: ________________

Address:______________________________ City:________________ State:________ Zip:____________

Phone: Cell:________________________ Home:________________________

Name:____ Relation to Patient: ________________

Address:______________________________ City:________________ State:________ Zip:____________

Phone: Cell:________________________ Home:________________________

IF PARENTS ARE DIVORCED OR SEPERATED, PLEASE FILL OUT THIS SECTION

Custodial Parent:____ Relationship: __Mom ___Dad ___Other:__________

Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ___Yes ___No

If Yes, please explain and provide a copy of any legal paperwork that supports this restriction:________________________________

____

Is the non-custodial parent legally responsible for medical bills? ___Yes ___No

If Yes, we must have a copy of any legal paperwork supporting this or a written statement from the non-custodial parent.

GUARANTOR *(the person financially responsible for medical care)*

Full Name:____ Relationship: ___Mother ___Father ___Other:__________

Address:______________________________ City:________________ State:________ Zip:____________

Phone: Cell:________________ Home:________________ Email:________________________

Statement delivery preference: ___Mail statements to address above ___Email statements to the email listed above

PHARMACY INFORMATION

Pharmacy Name:____

Address:____

Phone:______________________________ Fax:______________________________

PREFERRED METHOD OF COMMUNICATION

My preferred method of communication regarding patient's medical information is: ___Home Phone ___Cell Phone Other:____________________

Revised: 02/2018

I authorize Summit Pediatrics to leave a voicemail message on my preferred contact number for the following: (check those that apply)

____ Test Results ____ Referral Information ____ Specialist Information

CONSENT FOR TREATMENT

I understand that if Patient, which may be defined as me, my child, or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment as Summit Pediatrics, LLC. Treatment provided by medical providers, nurses, and medical assistants as Summit Pediatrics may include evaluation and management, vaccinations, laboratory and other testing; routine medical, nursing, and medical assistant care and procedures. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as order by attending physician/APRN.

I hereby give my permission for Summit Pediatrics, LLC. to treat myself/child/children, according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating Provider.

Parent/Guardian
Signature:____________________ Relationship to patient:____________________

Parent/Guardian
Printed Name:____________________ Date:____________________

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD

(ie. Nanny, Grandparent, Step-Parent, and/or teen by themselves)

In the event that someone other than the parent/legal guardian indicated on file brings the patient in for medical care, the person(s) listed below are authorized to accompany the patient:

Name:____________________ Relationship to Patient:____________________

Name:____________________ Relationship to Patient:____________________

Name:____________________ Relationship to Patient:____________________

ASSIGNMENT OF BENEFITS

I do hereby assign to Summit Pediatrics, all benefits and all interest and rights, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payer providing benefits for goods and services provided to Patient by Summit Pediatrics. I also authorize direct payment to Summit Pediatrics for the goods and services provided to Patient.

I further authorize the Patient's plan administrator, insurer, and/or attorney to release to Summit Pediatrics, any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Summit Pediatrics needed to claim medical benefits.

Parent/Guardian
Signature:____________________ Relationship to patient:____________________

Parent/Guardian
Printed Name:____________________ Date:____________________

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I Acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Privacy Practices For Summit Pediatrics, LLC.

Parent/Guardian
Signature:____________________ Relationship to patient:____________________

Parent/Guardian
Printed Name:____________________ Date:____________________

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT OF RECEIPT

OFFICE STAFF ONLY:

Written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices could not be obtained due to one of the following:

_____ *An emergency prevented us from obtaining acknowledgement*

_____ *A communication barrier prevented us from obtaining acknowledgement*

_____ *The individual was unwilling to sign* _____ *Other:*____________________

*Staff Member Signature:*____________________ *Date:*____________________

SUMMIT PEDIATRICS FINANCIAL POLICY

Patient Name:	Date of Birth	Patient Name:	Date of Birth

Summit Pediatrics is dedicated to providing excellent care and outstanding overall service to every patient at every visit. Summit Pediatrics participates with many of the major healthcare plans. Because the benefits and exclusions are provided to only the subscriber and the members in their family, Summit Pediatrics has no way of knowing what they include. **Therefore it is the responsibility of the guarantor and subscriber to know the coverage and benefits of their insurance.**

The following identifies the responsibilities of both Summit Pediatrics and the guarantor (parent or legal guardian).

SUMMIT PEDIATRICS'S RESPONSIBILITIES:

- To bill the managed care insurance plans we participate in
- To collect copayments at the time of service

IMPORTANT TO NOTE: Summit Pediatrics cannot guarantee or promise that all services provided at the time of visit will be covered by the patient's insurance plan or covered under one copayment.

Procedures performed in addition to the office visit, including but not limited to, a strep test, blood draw, ear wax removal, wart removal, asthma treatment, or lab tests may require an additional copay, coinsurance, and/or deductible based specifically on each patient's individual insurance plan.

For Well Child Checks: developmental screenings, lab tests, immunizations, etc., are considered separate billable procedures from the actual well child visit and may entail an additional coinsurance or deductible or possibly may not be covered by your insurance plan. ***If other health issues or problems are addressed at the time of a Well Child Check, a separate billable visit may be charged as an addition to the well child check visit, which may require an additional copay, coinsurance, and/or deductible based on your insurance plan benefits.***

GUARANTOR'S (PARENT OR LEGAL GUARDIAN) RESPONSIBILITIES:

- To verify that Summit Pediatrics are a participating healthcare provider with your insurance plan
- To verify that Summit Pediatrics is listed as the PCP (Primary Care Provider) with your insurance plan if required. If another provider is the PCP, we cannot bill your insurance. The patient may be seen, but payment will be due in full at time of visit.
- To know the benefits and exclusions provided by your insurance plan including the copayment amount, coinsurance, and deductible, as well as the effective and expiration date.
- To **provide at the time of each visit the insurance card** and all information required to bill the insurance
- To pay the required copayment at the time of service
- To pay all coinsurances and/or deductibles upon receipt of your statement from Summit Pediatrics
- To pay in full for any services your insurance may deny as "non-covered"
- To pay in full at the time of service for any services provided if we do not participate with your insurance plan
- For patients without insurance, self-pay charges are due in full at the time of service
- To contact the **Billing Office at 470-377-4244** if unable to pay in full upon receipt of statement to set up a payment plan
- To pay the $35.00 bank fee if a non-sufficient or returned check is provided as payment
- To pay the appropriate late cancellation or no-show fee for missed appointments
- To pay any collection fees that may be assessed if the account is turned over for collections

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SUMMIT PEDIATRICS FINANCIAL POLICY (cont.)

LATE CANCELLATION AND NO SHOW FEES

Summit Pediatrics requires a 24 hour notice to cancelling or rescheduling any appointments. Failure to do so will result in a **$25.00 missed appointment fee**. However, because consult appointments for ADHD require an extended amount of time with the doctor, late cancellations and no shows for these visits will result in a **$50.00 fee**. Failure to pay these fees and/or after 3 (three) missed appointments, you may be discharged from the practice.

In consideration of the services provided at Summit Pediatrics:

- **I, the undersigned, hereby assign** all medical provider benefits payable (i.e. "Payor", Insurance Coverage, Medicaid, etc.) and related existing under the Payor coverage that I have identified or will identify in connection with the services provided directly to Summit Pediatrics and acknowledge this includes my permission to submit all my patient health information (PHI), including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDs, etc.), for payment purposes. __ **This assignment will remain in effect until revoked by the patient/parent/legal guardian in writing.**
- **I understand** that any payment received by Summit Pediatrics for this period may be applied to any unpaid bill(s) for which I am liable.
- **I understand** that different Insurance Companies have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations, or that the services be medically necessary.
- **I understand** that it is my obligation to know my Insurance plan requirements for payment and ensure they have been fulfilled.
- **I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay Summit Pediatrics the full balance that is not reimbursed by my insurance company.**
- **I understand** that should my account become over 90 days past due from the date of service, your account may be turned over to an outside collection agency. Any charges incurred by Summit Pediatrics will be passed on to the guarantor of the account. This includes, but is not limited to, a **35% collection fee** paid to the agency, as well as legal or administrative fees.

By signing this form, I acknowledge that I have read, understood, and agree to the above financial policy set forth by Summit Pediatrics (if you would like a copy of this financial policy, please ask the front desk)

Parent/Guardian
Signature:______________________________ Relationship to patient:______________________

Parent/Guardian
Printed Name:______________________________ Date:______________________

FOR PATIENTS 18 AND OLDER (must sign if parent is to continue paying for medical services provided by Summit Pediatrics)

By signing this form, I agree to allow (parent/guardian name)______________________________, my (relationship to patient) ______________________, to be financially responsible for all of the expenses related to the medical care I may receive from Summit Pediatrics. I authorize the staff of Summit Pediatrics to disclose only the information specifically regarding my financial account with Summit Pediatrics to this individual. I further authorize Summit Pediatrics to send all statements or requests for insurance information to this individual without constraint. I understand that I may revoke these privileges at any time making my financial account solely my responsibility. I acknowledge that this authorization does not authorize Summit Pediatrics to fully disclose my medical record, and I must fill out the appropriate medical release of information for this.

Patient
Signature:______________________________

Printed
Name:______________________________ Date:______________________

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