Saint Alphonsus Medical Group

Financial Policy

We will file your insurance claims for you. We do request a copy of your current insurance card to ensure accurate billing. Please keep in mind we do not accept all insurances. If you do not have insurance or if your insurance does not cover the services you need from our clinic, payment is your responsibility. It is also your responsibility to confirm directly with your insurance company to find out whether or not we participate with them, and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay, deductible, or coinsurance, it is your responsibility to have it with you at the time of service. Failure to do so may result in us having to reschedule your appointment.

- **Medicaid Patients**: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require photo ID, which will be scanned into our computer system. Lack of this information may result in us having to reschedule your appointment.

- **Minors**: The parent/guardian accompanying the minor at the time of service is responsible for payment.

    - We will request payment at the time of service. If this is not possible, we will expect you to make acceptable payment arrangements, prior to receiving service.

    - You will receive at least two statements after to your visit to our clinic. If your account is not paid in full, or if you have not established an acceptable payment plan, we will refer your account to a professional credit bureau.

    - The credit bureau will send you a notification that a payment is due. The letter will arrive at your last known address. You must respond to this letter, to avoid damage to your credit record. If you do not respond to this letter, your account will be listed for collection and your credit will be adversely affected.

    - I understand and agree that if I fail to pay for services for which I am responsible, after such default and upon referral to a collection agency by Saint Alphonsus Medical Group, I will be responsible for all cost of collecting monies owed, including court costs, and collection agency fees.

We are disclosing our policy to you now to avoid misunderstanding in the future.

Saint Alphonsus Medical Group

Complete both sides

PEDIATRIC
PATIENT REGISTRATION

Date: _____

Patient

Last Name _____ First Name _____ Initial _____

Date of Birth _____ Gender: ☐ Female ☐ Male

Address _____

City _____ State _____ Zip _____

Phone – Home _____ Preferred Message/Contact Phone _____

Race (please circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other _____

Preferred Language _____

Has patient been seen at a Saint Alphonsus Medical Group or Express Care Clinic in the past 3 years?
☐ Yes ☐ No

Who was the patient's last provider? _____

Preferred Pharmacy _____

Major Crossroads _____

Health Insurance

Primary Insurance _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Office Staff: if unable to scan card, make copy of card and attach to this form. If card unavailable, but patient has group & subscriber number, please write numbers on this form.

People assisting with paperwork:

Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff name	Office Staff Signature	Date and Time

Place patient sticker here or handwrite

Name _____

DOB: _____

Saint Alphonsus Medical Group

Complete both sides

Guardian/ 1st Parent

Last Name _____ First Name _____ Initial _____

Social Security Number _____ Date of Birth _____ Sex _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone – Home _____ Work _____ Cell _____

Marital Status _____ Email _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Additional Contact (not living with you)

Last Name _____ First Name_____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

2nd Parent

Last Name _____ First Name _____ Initial _____

Social Security Number _____ Date of Birth _____ Sex _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Preferred Message/Contact Phone _____ Marital Status _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Place patient sticker here or handwrite

Name _____

DOB: _____

Complete both sides

Saint Alphonsus Medical Group

PEDIATRIC

PROTECTED HEALTH INFORMATION RELEASE

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally.

☐ You have my permission to speak with my Spouse (Stepparent/Significant Other) about my child's medical care.

Spouse (Stepparent/Significant Other)'s Name _____

Phone _____

☐ You have my permission to leave information on my answering machine regarding my child's medical care and test results.

☐ You have my permission to talk with these family members or caregivers about my child's care.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

☐ Other, please describe: _____

Are there currently any legal proceedings concerning the custody of this child? No ☐ Yes ☐

If yes, please explain: _____

Emergency Contact:

First Name _____ Last Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

Place patient sticker here or handwrite

Name _____

DOB: _____

Insurance/HIPAA E3 Peds
Rev 02-28-2012
Form 0203

Complete both sides

Saint Alphonsus Medical Group

PEDIATRIC PROTECTED HEALTH INFORMATION RELEASE, CONT.

OPTIONAL:

Parental/Guardian Consent for Medical Treatment when Parent/Guardian is not present:

Child's Information

Child's Name _____ Date of Birth _____ Home Phone Number _____

Home Address _____ City, State, Zip Code _____

Parent/Guardian Name _____ Parent/Guardian Phone _____

Caregiver Information

The following named person(s) shall be authorized to bring my child to medical appointments **in my absence**.
Please attempt to contact me at the following telephone number: _____ if you need any further authorizations.

Caregiver's Name and Relation _____ Phone Number _____

Caregiver's Name and Relation _____ Phone Number _____

Caregiver's Name and Relation _____ Phone Number _____

I agree to pay for all services provided to my child in my absence.

This authorization shall be effective from _____ (Month, Day, Year) until _____ (Month, Day, Year) or up to one year from the date below**.

By signing below I certify that I am the Legal Primary Caregiver of:

Patient's Name _____ Relationship to patient _____

Legal Primary Caregiver Name **(Please print)** _____ Legal Primary Caregiver Signature **(Please sign in office)** _____ Date and Time ** _____

Witness Name (Staff) _____ Witness Signature (Staff) _____ Date and Time _____

People assisting with paperwork:

Interpreter's name _____ Interpreter's Signature and/or ID # _____ Date and Time _____

Office Staff's name _____ Office Staff Signature _____ Date and Time _____

Place patient sticker here or handwrite

Name _____

DOB: _____

HAVE LEGAL PRIMARY CAREGIVER DATE AND INITIAL:

Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials

Insurance/HIPAA E3 Peds
Rev 02-28-2012
Form 0203

Saint Alphonsus Medical Group

Pediatrics

PLEASE REVIEW WITH YOUR NURSE/MA

If your child is over the age of 13 (Annual)

Do they use Tobacco products regularly, occasionally, or recreationally? No ☐ Yes ☐

Nutrition (Annual / as needed)

Have your child's eating habits changed for any reason since your last visit? No ☐ Yes ☐

Any change in appetite, ability to eat, or any foods or weight changes that affected them differently.
No ☐ Yes ☐

Functional Status (Annual / as needed)

Have you noticed any change in your [child's] ability to take care of him or herself or do any of your [child's] usual activities? No ☐ Yes ☐

Safety (Annual / as needed)

At any time do you feel concerned for the safety/well-being of yourself and/or your children, in your home or elsewhere?
No ☐ Yes ☐

Depression Screening (As needed)

Over the last 2 weeks, how often has your child been bothered by any of the following problems?

Little interest or pleasure in doing things: ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

Do you or your child have any barriers to learning? (Annual)

Such as: cognitive limitations, language, interpreter needed and/or physical limitations

How do you or your child best learn? (Annual)

Such as: audio materials, demonstrations, written materials verbal explanations, video materials

Social History (Annual)

Child primarily resides with _____Secondary_____

Parents' marital status:

☐ Married ☐ Lives Together ☐ Divorced ☐ Separated ☐ Other_____

Tobacco Exposure

Smokers at home No ☐ Yes ☐ If yes, smokes outside only No ☐ Yes ☐

See other side

Saint Alphonsus Medical Group

Past Medical History:

☐ ADD/ADHD	☐ Bronchiolitis	☐ Fracture	☐ Prematurity
☐ Abdominal Pain	☐ Bronchitis	☐ GERD	☐ Pyelonephritis
☐ Acne	☐ Chickenpox	☐ Headaches	☐ Recurrent otitis media
☐ Allergic Rhinitis	☐ Concussion/CHI	☐ Hearing Problems	☐ Seizure Disorder
☐ Allergies	☐ Congenital heart disease	☐ Heart Murmur	☐ Seizure-Febrile
☐ Anemia	☐ Constipation	☐ Menstrual Problems	☐ UTI
☐ Asthma	☐ Diabetes	☐ Migraines	☐ Vesicoureteral reflux
☐ Bleeding disorder	☐ Eczema	☐ Pneumonia	☐ Other _____

Past Surgical History and Year:

☐ Appendectomy	_____	☐ Adenoidectomy	_____
☐ Inguinal hernia repair	_____	☐ PET placement	_____
☐ Fracture with Surgical Reduction	_____	☐ Lymph node biopsy/excision	_____
☐ Dental surgery	_____	☐ Umbilical hernia repair	_____
☐ Tonsillectomy	_____		_____

Family (Father, Mother, or Sibling) History :

☐ ADD/ADHD	☐ Deafness	☐ High Blood Pressure	☐ Thyroid disease
☐ Alcoholism	☐ Depression	☐ Learning Disability	☐ Other
☐ Allergies	☐ Developmental delay	☐ Mental retardation	**Age/cause of death of:**
☐ Asthma	☐ Diabetes	☐ Migraines	Mother:
☐ Birth defects	☐ Eczema	☐ Scoliosis	☐ n/a _____
☐ Cancer: Type:	☐ Genetic Disorder	☐ Seizure Disorder	Father:
☐ CAD (Coronary Artery Disease)	☐ Hemoglobinopathy	☐ SIDS	☐ n/a _____
☐ DDH (Hip dysplasia)	☐ Hyperlipidemia	☐ Strabismus	Siblings:
			☐ n/a _____

See other side