A+ FAMILY HEALTH CHILD I.D. SHEET

Child's Name: _____ **Birth date:**_____ **Sex: M F**
Last First Middle Initial

Address: _____
Street City State Zip

Race: American Indian / Alaskan Native / Asian/ African American/ Black Hispanic or Latino / Native Hawaiian or Pacific Islander / White / White Hispanic or Latino / Refuse

SS# _____-_____-_____ **Advance Directives: (Circle One) YES NO Language Preference:**_____

Tel Home:( )_____ **Tel Work:( )**_____-_____ **E-mail:** _____

How Did You Find Us: Newspaper Yellow Pages Hospital Friend Drive by Referred by_____ Other: _____

List of Medications Patient is Taking Now? **Are You Allergic to any food or Medicine?**

_____ _____

_____ _____

PARENT OR LEGAL GAURDIAN'S INFORMATION

Name:_____ **Home Phone:**_____
Last First M. Initial

Address:_____ **Soc. Sec. #:**_____-____-_____
Street City Zip

Employer:_____
Name Address

Employer's Tel #:( )_____ **Relationship to Child:**_____ **Sex: M F**

INSURANCE INFORMATION

Self Pay: Yes No Medicare #:_____**Eff. Date:**_____
Medicaid #:_____ **Seq #:**_____ **Control #:** _____ **Eff. Date:**_____
Other Insurance :_____
Name Address Phone
ID #:_____ **Group #:**_____ **Eff. Date:**_____

EMERGENCY CONTACT PERSON

Name/Address:_____ **Relationship:**_____
_____ **Home Phone:( )**_____
_____ **Work Phone:( )**_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical / surgical benefits to **A+ FAMILY HEALTH** for services rendered by the doctors and staff. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICAID -- MEDICARE

I certify that the information given by me in applying for payments is correct. I request that payment of authorized benefits be made on my behalf.

CONSENT FOR TREATMENT

I_____**,** do hereby voluntarily consent to and/or authorize the performance of examinations, treatment, diagnostic procedures, blood tests and/or laboratory procedures, which the doctor(s) in attendance at the **A+ FAMILY HEALTH** considers necessary and/or appropriate. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition. This consent will remain in effect for as long as the patient remains a client of **A+ FAMILY HEALTH.**

I acknowledge receipt of **A+ FAMILY HEALTH, NOTICE OF PRIVACY PRACTICES and PATIENT CONSENT FORM. (Please complete on back.)**

A photocopy of these assignments shall be valid as the original.

SIGNATURE:_____ **PATIENTS NAME:**_____
Please Print

AUTHORIZED PERSON: _____ **DATE:**_____
Please Print Name **Relationship.**

A+ FAMILY HEALTH.

Patients Name:_____

Authorization and Consent for The Use and/or Disclosure of Protected Health Information.

I have been given a copy of **A+ FAMILY HEALTH** Notice of Privacy Practices that provides more detailed information about how they may use and disclose my protected health information. I have the right to read this Notice of Privacy Practices before signing the consent.

The Physicians and employees of **A+ FAMILY HEALTH** will use and disclose your protected health information for the purposes of treatment, payment and health care operations unless you request a restriction as outlined in our Notice of Privacy Practices.

1. I authorize the use and/or disclosure of my protected health information to:
   _____

My authorization applies to the following information, only this information may be used and/or disclosed pursuant to this authorization: NAME & ADDRESS _____ PHONE # _____ SS # _____ BILLING INFO _____ MEDICAL RECORDS_____OTHER_____.

2. You can authorize additional persons or classes to receive your protected health information. Without this authorization we are prohibited from divulging your health care information, even to your spouse or other family members. If you wish to allow others access to your health care information please include their name and relationship in the following area:-
   SPOUSE____ CHILDREN____ BROTHER/SISTER____ PARENT(S)____ OTHERS_____

Include Name(s)_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time as outlined in the Notice of Privacy Practices. If applicable this authorization expires upon _____

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from **A+ FAMILY HEALTH**, nor will it affect my eligibility for benefits.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. § 164.524)

_____ _____

Signature Date

Payment Policy

Thank you for choosing **A+ FAMILY HEALTH** as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**