Patient Information

Date _____

ADDRESS

Patient's Name_____ M / F DOB_____ SSN_____

Mailing Address_____, _____, _____, _____
PO Box or Street City State Zip

Email Address_____

Primary Phone/Relation_____ Secondary Phone/Relation_____ Other Phone_____

CONTACT--Only complete this section if patient is under the age of 18. Please check box next to Primary Emergency Contact.

□ Mother's Name_____ DOB_____ SSN_____

Mailing Address_____, _____, _____, _____
PO Box or Street City State Zip

□ Father's Name_____ DOB_____ SSN_____

Mailing Address_____, _____, _____, _____
PO Box or Street City State Zip

OTHER

Primary Language_____ Race_____ Ethnicity_____

Please list below who may have access to the patient's medical information and the relationship to the patient. All persons listed will be authorized to accompany patient at appointments and act as a medical decision maker on the patient's behalf.

Authorized Person's Name_____ Relationship_____

Authorized Person's Name_____ Relationship_____

Authorized Person's Name_____ Relationship_____

Primary Care Doctor _____

BILLING

Person Responsible for Medical Expenses_____ Relationship_____

PRIMARY INSURANCE

Insurance Company_____ Subscriber ID _____

Subscriber Name_____ Subscriber Date of Birth _____

Subscriber Social Security Number _____

SECONDARY INSURANCE—if applicable

Insurance Company_____ Subscriber ID _____

Subscriber Name_____ Subscriber Date of Birth _____

Subscriber Social Security Number _____

Completed By:

_____ _____
Signature of Patient/Guardian *Date*

Acknowledgements and Authorizations

Thank you for choosing The Pediatric Center and/or Sabine Urgent Care as your medical home. We are dedicated to providing the best possible care for your family, and we want you to understand our policies.

Authorization for Treatment and Acknowledgement of Privacy Practices

1. By signing this document, I acknowledge my consent for treatment.
2. It is imperative for parents of minor patients to understand that The Pediatric Center and/or Sabine Urgent Care strictly adhere to Custody Judgements as ordered. It is not the responsibility of The Pediatric Center and/or Sabine Urgent Care to act as intermediary between parents, however, it is our request that current Custody Judgements are provided to our clinic to be stored in the patient's medical record in order to avoid any conflict that might arise.
3. I certify to the best of my knowledge the information included in this New Patient Packet is correct.
4. I understand that The Pediatric Center and/or Sabine Urgent Care complies with all HIPAA regulations and that the Notice of Privacy Practices and Patient Rights and Responsibilities is included with this packet for my review.
5. I understand that The Pediatric Center and/or Sabine Urgent Care may leave messages on your answering machine as well as text message reminders of appointment confirmations, requests to call our office, and/or other necessary communication regarding the patient's medical care.
6. The Pediatric Center and/or Sabine Urgent Care will not release printed or electronic copies of medical records without a signed consent. If you wish to receive copy of a medical record, the charge will be $10. If you wish for records to be transferred to another medical provider, we will do so free of charge. Please consult with our office if you wish to have records transferred from another provider to our office.

Authorization and Acknowledgement of Insurance and Financial Policies

7. I authorize The Pediatric Center and/or Sabine Urgent Care to review my insurance coverage with my insurance company as indicated.
8. I authorize The Pediatric Center and/or Sabine Urgent Care to release medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered.
9. I further authorize the release to The Pediatric Center and/or Sabine Urgent Care of such information as may be necessary by my insurance company.
10. I permit a copy of this authorization to be used in place of the original.
11. I hereby authorize you to pay directly to The Pediatric Center and/or Sabine Urgent Care benefits due me out of my indemnity under the terms of my insurance company policy.
12. Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim. If your insurance company does not pay the practice within 60 days from the date of service, you could bebilled for the balance remaining. If we later receive payment from your insurance company, we will refund any overpayment to you.
13. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. You may be required to pay a copayment at the time of your visit, and the remaining amount will be billed to your insurance company. Non-payment of a copayment for a visit is a violation of the contract between you and your insurance company.
14. Payment is due at the time of check-in for any services rendered. We accept checks, cash, and all major credit and debit cards excluding American Express. Your insurance policy is reviewed prior to every service and if proof of insurance cannot be verified at the time of service, you will be responsible for payment of all services at time of check-in. If you have an outstanding balance on your account, payment is due at the time of check-in as we send monthly statements showing balances in an itemized format.
15. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means your insurance company will send any payment directly to you; therefore, you are responsible for payment in full at the time of service.
16. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "non-covered," you will be responsible for the entire charge. Payment is due upon receipt of a statement from our office.
17. If checks are returned for Non-Sufficient Funds (NSF), you will be charged for any customary bank feesfor the returned check. In this case, you would no longer have the privilege of writing checks to our clinic—you would have to pay with cash or credit or debit card only.
18. Please be informed that it is your responsibility to provide The Pediatric Center and/or Sabine Urgent Care with your correct address in cases of which your information changes. It is also our request that if the patient's parents are divorced, you provide us with a copy of the divorce decree or custody paperwork showing who has financial responsibility for medical expenses.
19. If balances tend to exceed past 90 days or more, your account could be referred to a collection agency. After 60 days of the account being referred and receiving no resolution, any outstanding balances at that time could create a blemish on your credit report for up to 7 years.
20. Laboratory specimens may be sent to a reference laboratory for testing. By signing below, you consent to The Pediatric Center and Sabine Urgent Care providing the reference lab with my demographic information as necessary for billing purposes. Reference laboratories generally bill separately for their services. Billing questions or issues concerning specimens should be addressed with the reference lab and not The Pediatric Center and/or Sabine Urgent Care. It is important that patients be informed of which laboratories are in-network with their insurances. If a specimen is sent to a laboratory that is not in-network with a patient's insurance, the patient could be left responsible for the entire charge of services. Please inquire at the time of specimen collection if you are unsure if your insurance is in-network with our reference lab.

I have read and understand the practice's Acknowledgements and Authorizations notice and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice periodically.

_____	_____	_____
Patient's Name	**Signature**	**Date**

Notice of Privacy Practices and Patient Rights and Responsibilities

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to coordinate treatment, payment, or healthcare operations and other purposes that are required by law. It also describes your rights to access and control your PHI. PHI includes information that may identify you and that relates to your past, present, or future physical or mental health and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

PHI may be used and disclosed by our practice and other medical professionals that are involved in your care, to facilitate payment of services, and any other use required by law.

Treatment. We will use and disclose PHI to provide and coordinate medical care. This would include a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment. PHI will be used to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that relevant PHI be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations. We may use or disclose PHI to support the business activities of THE PEDIATRIC CENTER AND/OR SABINE URGENT CARE. These activities include, but are not limited to, quality assessment activities, employee review activities, and training of medical provider students. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call patients by name in the waiting room at the time of service and use PHI to confirm appointments.

Other. We may use or disclose PHI in the following situations without your authorization to include: as required by law; Public Health issues; Communicable Disease; Health Oversight Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Criminal Activity; Military Activity and National Security; Workers' Compensation; and Inmates Required Uses and Disclosures. Under the law, we must make disclosures as required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other permitted and required uses and disclosures will be made only with your consent.

Patient Access to Medical Records. *You have the right to review and copy your PHI.* Under federal law, however, you may not review or copy the following records: psychotherapy notes, information completed in anticipation of a civil, criminal, or administrative action, and PHI that is subject to law that prohibits access to PHI. *You have the right to receive an accounting of certain PHI disclosures made on your behalf.*

You have the right to request a restriction of your protected health information. Your request must state the specific restriction requested and to whom you want the restriction to apply. *Our office is not required to agree to a restriction that you may request.* If your provider believes it is necessary to permit use and disclosure of your PHI, the restriction will not be granted.

You have the right to request to receive confidential communications from us by alternative means.

You have the right to request amendment of your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we will review your request further.

Patient Rights and Responsibilities

Patients have a right to:

i. Receive information about services and providers
ii. Be treated with respect in recognition of their dignity and right to privacy.
iii. Participate with providers in decision making regarding their health care inclusive to:
    a. Attaining written consent to treat
    b. Make the final determination in the course of action among clinically acceptable choices
    c. Be represented by parents, guardians, family members, or other conservators when the patients are unable to fully participate in their treatment decisions with proper legal documentation
    d. Acknowledgment of advanced directive.
iv. Discussion of appropriate or medically necessary treatment options for their conditions
v. Voice complaints or appeals about their care through the complaint process
vi. Be represented by parents, guardians, family members or other conservators when the members are unable to fully participate in their treatment decisions with proper legal documentation
vii. Discuss potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms. Practitioners will educate patients regarding their health needs and share findings of history and physical examinations.
viii. Make the final determination regarding clinically acceptable choices.
ix. Have an Advance Directive acknowledged by the clinic.

Patients have the responsibility to:

i. Provide, to the extent possible, information that its providers need in order to care for them. If patient has an advanced directive, it is imperative that patients provide this information to the clinic for acknowledgement.
ii. Follow the plans and instructions for care that they have agreed on with their providers.

Complaints. You may submit a complaint if you believe your rights have been violated. Please contact our Practice Manager at (337) 239-2207. In the event your complaint remains unresolved with The Pediatric Center and/or Sabine Urgent Care, you may file a complaint with our accreditor, The Compliance Team, Inc. via their website (www.thecomplianceteam.org) or via phone at (888) 291-5353.

We are required to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this document, please ask to speak with our Practice Manager. ***The Pediatric Center and/or Sabine Urgent Care reserve the right to change the terms of this notice.***

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices and Patient Rights and Responsibilities.

Patient's Name	**Signature**	**Date**