Redmont Pediatric Associates, P.C. Financial Responsibility/HIPAA/Consent

Patient's Name (Print Please): _____ **DOB:** _____

I hereby assign to Redmont Pediatric Associates, P.C. all payments for medical services rendered. I acknowledge full financial responsibility for all services provided, both those covered by my insurance contract and those non-covered services that may be deemed necessary for appropriate medical care. **I ACCEPT FULL** responsibility for knowing what my insurance benefits are and will advise the staff of Redmont Pediatric Associates, P.C. accordingly should my benefits change. I understand that charges incurred are **DUE AT THE TIME OF SERVICE.**

I also understand that fees may be incurred for other services provided. **I acknowledge and agree to pay the following Administrative Fees should they be incurred on my account. Administrative Fees are as follows: $25.00 Cancellation Fee or NO SHOW Appointment Fee for a check-up appointment (Please call within 24 hours to cancel any check-up appointment. When patients cancel the same day of their appointment or simply NO SHOW this takes away our ability to see another patient who needs to be seen). $35.00 NSF/Returned Check Fee. $5.00 Form Fee for processing of forms requested by me (blue forms, shot records, sports physical forms, camp forms etc...). $25.00 FMLA Form fee.**

I agree to pay **33% of the unpaid balance for collections costs**, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court. I further understand that payment is due at time of service and my child may not be seen if my account is in collections.

I hereby waive all rights to claim exemption of personal property and wages from execution, garnishment or attachment pursuant to a lawful judgment otherwise granted to me under the laws and constitutions of the State of Alabama and the United States.

In cases where parents are <u>not married, divorced and/or separated</u>, the person bringing the child in for services will be obligated to pay for any co-pays or balances that are due at the time of service. The legal guardian and /or the person bringing the child in for services will be held responsible for paying any balance resulting from that visit. If legal documentation is presented that someone other than the legal guardian is financially responsible, and accurate billing information can be provided, we will attempt to bill that party. Ultimately, in the State of Alabama, both biological parents are responsible for debts incurred by their minor children.

You may use your MasterCard, Visa, Discover and AMEX to charge current services or any outstanding balance on your account. For your convenience, credit card payments can be made via our website and Patient Portal.

Signature of Parent/Guardian: _____ **Date:** _____
(My signature states that I agree to financial responsibility)

The responsible party understands that no oral or written contract exists which designates by name or description the individual who will treat the patient. I understand that any release of information or consent to treat other than the authorizations listed above will require my written or verbal approval.

Signature of Parent/Guardian: _____ Date: _____

Mother's Place of Employment: _____ **Work Phone Number:** _____

Mother's SSN: _____

Father's Place of Employment: _____ **Work Phone Number:** _____

Father's SSN: _____

HIPAA Notice of Privacy Practices

I have received a copy of Redmont Pediatric Associates, P.C. Notice of Privacy Practices. I am aware that this office is HIPAA compliant and is following federally regulated guidelines regarding my protected health information.

Signature of Parent: _____ **Date:** _____

Signature of Patient (Age 14-19): _____ **Date:** _____

Consent for Use and Disclosure of Protected Health Information

I hereby consent for Redmont Pediatric Associates, P.C. to use or disclose information about me or my child (or another person for whom you have the authority to sign) that is protected under federal law for the purposes of treatment, payment and healthcare operations. Due to recent changes involving federal laws regarding patient privacy, our authorizations are more extensive than ever before. Please understand that the goal of Redmont Pediatric Associates, P.C. is to administer the best medical care available in the most efficient manner. We will always strive, to the best of our ability, to protect the privacy of our patients. Please understand that in the normal course of running our medical office, discussions can sometimes be overheard. Ask at any time if you would like to assure a totally confidential discussion with one of the doctors, lab technicians, nurses or business staff members.

Please carefully read the authorizations below and sign appropriately.

I hereby authorize Redmont Pediatric Associates, P.C. to communicate information to any referring or consulting physician, to any medical facility or to my insurance carrier by facsimile, electronic transmission, telephone or U.S. mail. My personal information is protected under federal law and I have the right to revoke this consent at any time. By signing below, I recognize that the protected health information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

****Signature of Patient or Parent:** _____ **Date:** _____

(If under age 14, must be signed by parent or guardian)**

For Adolescent Patients Ages 14-19 ONLY!!!

I hereby authorize the physicians of Redmont Pediatric Associates, P.C. to discuss my medical condition and treatment plan with my parent or guardian. I understand that if financial responsibility is assumed by my parent or guardian, they will have the right to review services rendered. I have the right to ask for a private consultation with my physician at any given time.

Signature of Patient Ages 14-19: _____ **Date:** _____

Authorization To Bring Patient For Medical Treatment

I give my consent for medical treatment from the physicians of Redmont Pediatric Associates, P.C. I also authorize the following individual to bring my child for medical treatment or call to speak to a doctor or nurse for medical advice. In case of any emergency, I may be reached by telephone for verification if the person accompanying the patient is not named below.

(Please list anyone you would authorize to bring your child to the doctor if you or the other parent cannot)

Name	Phone	Relationship to the Patient
_____	_____	_____
_____	_____	_____

Redmont Pediatric Associates, P.C. New Patient Form

The following information is REQUIRED for Redmont to see your child, please fill out entirely!

Patient's Name (first, middle, last): _____

Nickname: _____ **Male:** ____ **Female:** ____ **Birthdate:** _____

Home/Billing Address: _____

Patient's Personal Cell Number if over age 14: _____

Who is financially responsible for this patient: _____

Mom's Name: _____ **Mom's SSN:** _____

Mom's Cell Phone: _____ **Alternate Phone:** _____

Mom's Email Address: _____

Mom's Place of Employment: _____ **Birthdate:** _____

Dad's Name: _____ **Dad's SSN:** _____

Dad's Cell Phone: _____ **Alternate Phone:** _____

Dad's Email Address: _____

Dad's Place of Employment: _____ **Birthdate:** _____

Emergency Contact: _____ **Emergency Phone:** _____

Insurance Company: _____ **Effective Date:** _____

Name of Insured: _____ **Birthdate:** _____

Policy Number: _____ **Group Number:** _____

Siblings in our practice: _____ **Birthdate:** _____

_____ **Birthdate:** _____

Race, Ethnicity and Preferred Language

Patient Name: _____

Date of Birth: _____

Race (feel free to mark More Than One if needed):

___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ Prefers Not To Answer
___ White

Ethnicity (please mark only One):

___ Hispanic or Latino
___ Not Hispanic or Latino
___ Prefers Not To Answer

Preferred Language (Please mark only One):

___ English
___ Spanish
___ Prefers Not To Answer
___ Other: _____

Redmont Pediatric Associates

Medical History Form

Patient's Full Name (child)	Date of Birth	Preferred Name (nickname)
Mother's Name	Date of Birth	Occupation
Father's Name	Date of Birth	Occupation

List all others living in home – name, age, relation:

Social History (please circle below)

Are mother and father: Married Divorced Separated Engaged Remarried

If separated or divorced, who has custody?

Does anyone other than the parent have custody? YES NO

If yes, please specify: _____

Does anyone in the house smoke? YES NO

Does this child attend daycare? YES NO

Birth History

Full term – 37 weeks or greater? YES NO

How many weeks? _____

Type of delivery? (circle one) Vaginal C-Section

Reason for C-section? _____

Any problems in the hospital or the baby's first few months of life (jaundice, infection, breathing)? _____

Cholesterol Screening (please circle below)

Has your child ever had a high cholesterol? YES NO UNSURE

Parents or Grandparents with stroke or heart disease before 55 for men and 65 for women? YES NO UNSURE

Parent with cholesterol greater than 240 or on cholesterol meds? YES NO UNSURE

Past Medical History

Prior physician or source of care: _____

Does your child see a dentist? YES NO

Has your child been hospitalized? YES NO

If so, why? _____

Has your child ever had surgery? YES NO

If so, what for? _____

What medications does your child take regularly? _____

Any allergies or reactions to medicines or food? YES NO

If so, what kind of reaction (rash, breathing problems)_____

Does your child smoke or use tobacco? YES NO

Does your child use alcohol or drugs? YES NO

Past Medical History

Has your child ever had a history of any of the following? If so, please add year of onset in space provided.

ADD/ADHD_____
Allergies_____
Anemia_____
Asthma/Wheezing_____
Behavior Problems_____
Bleeding Problems_____
Broken Bones_____
Cerebral Palsy_____
Chicken Pox_____
Depression_____
Developmental Delay_____
Diabetes_____
Eczema_____
Hearing Problems_____
Heart Problems_____
Heart Murmur_____
HIV/AIDS_____
Immunity Problems_____
Kidney Problems_____
Migraines_____
Neuro. Problems_____
Pneumonia_____
GI Reflux_____
Seizure Disorder_____
Sickle Cell Disease_____
Sickle Cell Trait_____
UTI_____
Vision Problems_____

If you have had any of the problems above please be more specific (what kind of heart problems, which bones were broken, etc.)_____

Family History

If a parent, brother, sister, maternal/paternal grandparent, aunt, or uncle have any of the following, please INDICATE WHO in the space provided. Please also indicate what type/kind when prompted to do so.

ADD/ADHD_____
Alcoholism_____
Allergies_____
Anemia_____
Asthma_____
Breathing Problems_____
Cancer_____
Cystic Fibrosis_____
Depression_____
Diabetes (type?)_____
Drug Abuse_____
Hearing Loss_____
Heart Problems_____
Hepatitis (type?)_____
High Blood Pressure_____
HIV/AIDS_____
Schizophrenia_____
Sickle Cell Disease_____
Sickle Cell Trait_____
Stomach/GI Problems(type/kind)_____
Tuberculosis_____
Vision Problems_____

INDICATE WHO in the space provided above.