Pediatric & Adolescent Associates, P.S.C.

# Patient Profile

## PATIENT INFORMATION

Patient's Name: ____________________ Sex: [ ] M [ ] F DOB: ____________ SSN#____________

Address: ____________________ City: ____________ State: ______ Zip: ______

Ethnicity: ____________________ Race: ____________________

☆ Text Message or Email for Appointment Reminders: Text (cell phone): ____________ or Email: ____________

| Sibling's Name: | Sibling's DOB: | Sibling's Sex: | Sibling's Ethnicity: | Sibling's Race: |
|---|---|---|---|---|
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## PRIMARY GUARDIAN/FINANCIALLY RESPONSIBLE:

Name: ____________________ Phone #: ____________ [ ] Home [ ] Work [ ] Cell

Address: ____________________ Email Address: ____________

City/State/Zip: ____________________ Employer: ____________

Date of Birth: ____________________ Social Security #: ____________

**Other Parent/Guardian Contact Information:**

Name: ____________________ Phone #: ____________

Address: ____________________ DOB: ____________ Social Security #: ____________

City/State/Zip: ____________________ Employer: ____________

## PRIMARY INSURANCE INFORMATION INSURANCE HOLDER

Insured Party: ____________________ Company: ____________

Insured Address: ____________________ City/State/Zip: ____________

Insured Phone: ____________________ Insured ID: ____________

Insured Social Security #: ____________________ Policy Group: ____________

Insured Date of Birth: ____________________ Copay/Coinsurance: ____________

Patient Relationship to Insurance Holder: ____________________

## IMPORTANT CONTACTS

Name: ____________________ Phone: ____________ Relationship: ____________

Name: ____________________ Phone: ____________ Relationship: ____________

☆ Preferred Pharmacy: ____________ Address: ____________ Phone #: ____________

- Insurance Coverage is a contract between you and your insurance company. It is your responsibility to know what your plan does and does not cover.
- We will file insurance claims for you, but you are responsible for amounts not paid by insurance within 90 days.
- I understand that I am responsible for any balance not covered by insurance. I also understand that all co-payments, deductibles and co-insurances are due at the time of service.
- As parent or legal guardian, I authorize payment of medical benefits to be made directly to Pediatric & Adolescent Associates, PSC for services performed. I further agree to be fully responsible for all lawful debts incurred for services provided.
- I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to our account with Pediatric & Adolescent Associates, PSC.

→ ____________________ ____________

*Signature of Parent/Guardian* *Date*

# Pediatric & Adolescent Associates, P.S.C.

## *FINANCIAL POLICY*

Thank you for choosing Pediatric & Adolescent Associates, PSC as your pediatric primary care provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients/parents must complete this form prior to seeing the Pediatrician.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and resolve any outstanding balances in a timely manner.

***Insurance:*** Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by your insurance. If the insurance company has not processed and paid the claim within 90 days, then payment of the account will become the responsibility of the parent/legal guardian. In the event of a separation/divorce, the parent bringing the child for the appointment is responsible for payment of the copay, which is due at the time service is rendered. If one parent specifically is responsible for medical bills, that parent must sign this form. If you sign this form, you will be held responsible for any amount owed and it will be your responsibility to collect from the other party.

***Demographic Information & Insurance Cards:*** It is extremely important that we have updated demographic data from both parents so that we will be able to contact you in the future. We also must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing by your insurance and those claims would become your financial responsibility.

***Network Providers:*** It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify. You may contact our Business Office, if you have additional questions regarding network eligibility.

***Co-Pays, Co-Insurances & Deductibles:*** I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. I understand that I am responsible for any balance not covered by my insurance.

***Returned Checks:*** I understand that I will be charged an additional fee of $25 for any returned check.

***Weekends/After Hours:*** I understand there is an additional fee for appointments on late evenings, weekends and holidays that may or may not be covered by my insurance.

***Cancellation of Appointments:*** As a courtesy to other patients and the physicians, we require an advance notice prior to canceling appointments. You will be charged a fee if you fail to show up for a scheduled appointment and/or cancel a check-up appointment on the day of the visit.

***Payment:*** We accept Cash, Check, Money Orders, Mastercard, Visa, American Express, Discover and Debit Cards for payment. You may be contacted by our office at any of your contact numbers listed to attempt to resolve any outstanding balances. In the event that the account is not resolved, I understand that my account may be turned over to a collection agency and my child/children will be terminated as patients of Pediatric & Adolescent Associates, PSC.

***Assignment of Benefits/Authorization:*** As parent or legal guardian, I authorize payment of medical benefits to be made directly to Pediatric & Adolescent Associates, PSC for services rendered. I further agree to be fully responsible for all lawful debts incurred for services provided.

*Signature of Parent/Guarantor/Legal Guardian* ______ *Print Name* ______ *Date* ______

**(Please list the name of every child)**

**Patient(s):** ______________________________

______________________________

# *PEDIATRIC & ADOLESCENT ASSOCIATES, PSC*

## Consent to Treat/Medical Records/Privacy

I, ______________________________, the parent/legal guardian of the below named child(ren),

| Name of Child | Date of Birth | Sex |
| --- | --- | --- |
| | | |
| | | |
| | | |

Hereby authorize and consent to the examination and/or treatment of my child(ren) during office and facility visits by the physicians and clinical staff of Pediatric & Adolescent Associates. In addition, I give permission for the following person(s) to bring my child to PAA in my absence and to act in my behalf in authorizing medical care and treatment in my absence. In the event of emergency or other illness, I understand that the physicians and staff of PAA will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, PAA will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

## Medical Records/Privacy

At Pediatric & Adolescent Associates, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of PAA, kept in a secure location, and are accessed for only purposes outlined by the *Notice of Privacy Practices*. Records may be released or shared with other health care providers for treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed.

- ▶ I have received a copy, or been made aware I may have access to a copy, of the updated Notice of Privacy Practices from Pediatric & Adolescent Associates.
- ▶ I understand that PAA, its attorney and/or its agents including collection agencies may call my home, cell phone & place of employment for healthcare reasons, appointment reminders and to resolve billing issues.
- ▶ I understand that PAA, its attorney and/or its agents including collection agencies may contact me through email if I provide my email address at any time.
- ▶ I understand that PAA may use postcards to notify me of appointments or other pertinent information.
- ▶ I understand that PAA may fax immunization certificates, school excuses, physical/sports forms, and/or medication instructions to my personal or work fax, or my mail to my home. *PAA cannot fax or send these documents to third parties (schools, daycares, etc.) without a separate, signed authorization form.*
- ▶ I understand that PAA may leave messages on my answering machine regarding appointments and limited lab information.
- ▶ I understand that PAA may discuss patient information with adults or other minors present during the visit.
- ▶ ***I understand and agree to all of the above unless I strike through one of the statements.***

→ ______________________________ ______________

*Signature of Parent/Guardian* *Date*

Pediatric & Adolescent Associates, P.S.C.

# AUTHORIZATION FOR RELEASE OF INFORMATION
## To Schools & Daycares

Must be completed for all authorizations

**I hereby authorize the use or disclosure of my health information as described below.** By signing this authorization, I authorize Pediatric & Adolescent Associates to use and/or disclose certain protected health information (PHI) about me to the entity listed below.

Patient Name: ______________________ D.O.B.: ____ / ____ / ____ Patient Name: ______________________ D.O.B.: ____ / ____ / ____

Patient Name: ______________________ D.O.B.: ____ / ____ / ____ Patient Name: ______________________ D.O.B.: ____ / ____ / ____

Organization/Persons receiving the information: (Please list name and address.)

School Name: ______________________ Daycare Name: ______________________ Other: ______________________

____________________________________________________________

This authorization permits Pediatric & Adolescent Associates to use and/or disclose the following individually identifiable health information about me (circle one or more of the following and/or specifically describe the information to be used or disclosed):

Immunization Certificates, school excuses, school forms, medication instructions: ______________________

____________________________________________________________

For the following purpose: As requested by school, daycare, or parent via mail, phone or fax.

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I do not have to sign this authorization in order to receive treatment from Pediatric & Adolescent Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 3050 Harrodsburg Road, Lexington, KY 40503

☐ **I do not authorize the release of health information to schools or daycares.**

☐ I understand that this authorization is valid for 1 year from date signed, unless revoked in writing.

→ ______________________ ______________________ ______________________
*Signature of Patient or Legal Guardian* *Print Name* *Date*

______________________
*Relationship to the Patient*