CHATTANOOGA PEDS DEMOGRAPHICS

Circle One: **Established Patient** **New Patient** **Change of Address** **Update**

Patient information:

Full Legal Name:_____ Preferred name to be called:_____

DOB:_____ Gender: M/F SS#_____

Address:_____

Parent/Legal Guardian information: **Email :_____**

Full Legal Name:_____ Preferred name to be called:_____

DOB:_____ Gender: M/F SS#_____

Address if different from patient:_____

Cell #:_____Work#_____Employer:_____

Spouse information:

Full Legal Name:_____ Preferred name to be called:_____

DOB:_____ Gender M/F SS#_____

Address if different from patient:_____

Cell #:_____Work#_____Employer:_____

Marital Status of Parents: Single Married Divorced Widowed Separated

Insurance Information:

Primary Company Name:_____ Policy ID:_____ Group #_____

Policy Holder's Name:_____ DOB:_____ SS#_____

Secondary Company Name:_____ Policy ID:_____ Group #_____

Policy Holder's Name:_____ DOB:_____ SS#_____

_____**Insurance Assignment**- I authorize payment of medical benefits from **See Copy ID Card** insurance company to be paid directly to Chattanooga Peds for services render

_____ **Cash Policy**- I do not have insurance benefits available and agree to pay for all services rendered at time they incur, unless otherwise agreed to in the form of a financial payment contract.

__X___Consent to Treat : I hereby give my consent for Chattanooga Peds to examine and render treatment to**_____Above Name Child_____.**

Signature:_____ Date:_____

FINANCIAL POLICY AND PROCEDURE AGREEMENT

- I ACKNOWLEDGE THAT MY CHILD MAY BE SEEN BY MORE THAN ONE CLINICIAN DEPENDING ON THEIR NEEDS AND WILL BE BILLED APPROPRIATELY FOR EACH INDIVIDUAL CLINICIAN.
- **COPAYS ARE DUE AT TIME OF SERVICE**. WE ACCEPT VISA, MASTERCARD, DISCOVER, CHECKS AND CASH. A FEE OF $40 WILL BE CHARGED FOR ANY RETURNED CHECKS.
- AS A COURTESY, WE FILE YOUR INSURANCE. IF YOUR INSURANCE COMPANY HAS NOT PROCESSED AND PAID YOUR CLAIM WITHIN 90 DAYS FROM THE DATE OF SERVICE, **IT IS YOUR RESPONSIBILITY TO CLEAR YOUR ACCOUNT.**
- **FOR ANY PATIENT BALANCE THAT CAN'T BE RESOLVED WITHIN 90 DAYS, A PAYMENT PLAN MAY BE DISCUSSED.** THIS MUST BE HANDLED IN A TIMELY MANNER. IF THE DEBT CAN NOT BE RESOLVED, YOUR ACCOUNT WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY. YOU WILL BE RESPONSIBLE FOR ALL COLLECTION AGENCY FEES, ATTORNEY FEES, COURT COSTS AND ANY OTHER COSTS RELATED TO THE COLLECTION PROCESS.
- **WE WILL NOT GET INVOLVED WITH DIVORCE DECREE AGREEMENTS.** THE PARENT OR GUARDICAN THAT BRINGS THE CHILD IS RESPONSIBLE FOR COPAYS AND WILL BE ASK TO RESOLVE ANY BALANCE ON THE ACCOUNT.
- IF THE PARENT OR LEGAL GUARDIAN IS NOT BRINGING THE CHILD TO THEIR APPOINTMENT, A CONSENT FORM MUST BE SIGNED. CHATTANOOGA PEDS REQUIRES A HIPAA FORM TO BE SIGNED YEARLY. THERE IS A SPACE PROVIDED ON THAT FORM TO LIST WHO HAS CONSENT TO BRING THE CHILD FOR MEDICAL TREATMENT AND/OR RECEIVE MEDICAL INFORMATION.
- WE CAN EMAIL RECEIPT OF PAYMENT MADE BY PHONE BUT IT **WILL NOT BE ENCRYPTED**.
- ANYONE WHO IS SELF PAY WILL BE GIVEN A DISCOUNT AND PAYMENT IN FULL IS EXPECTED AT CHECKOUT.
- MOST INSURANCE COMPANIES REQUIRE POLICY HOLDERS TO UPDATE THEIR COB YEARLY. THIS IS YOUR COORDINATION OF BENEFITS WHICH MEANS THEY ARE VERIFYING IF YOU HAVE ANY OTHER COVERAGE PRIOR TO PAYING CLAIMS. YOUR EOB (EXPLANATION OF BENEFITS) WILL TELL YOU WHAT IS NEEDED BY YOUR INSURANCE COMPANY AND WHAT YOUR RESPONSIBILITY IS. **IF YOUR COB IS NOT COMPLETED IN A TIMELY MANNER, THE SERVICES RENDERED ARE PATIENT RESPONSIBILITY.**
- **A COPY OF YOUR INSURANCE CARD MUST BE PROVIDED AT EACH VISIT TO PROCESS YOUR CLAIM.**
- **ANY NON-COVERED CHARGES WILL BE IN YOUR RESPONSIBILITY.**
- IF YOUR ACCOUNT IS IN **BAD DEBT** AND SENT TO THE COLLECTIONS AGENCY, I UNDERSTAND THAT IF I DO NOT SET UP A PAYMENT PLAN WITH THEM OR PAY MY BALANCE IN FULL THAT CHATTANOOGAPEDS PEDS CAN DISMISS ME FROM THE PRACTICE.
- ***EVERY CHILD IN THIS PRACTICE MUST STAY UP TO DATE WITH ALL VACCINATIONS REQUIRED BY THE CDC AND THE STATE. IF I DO NOT KEEP MY CHILD UP TO DATE ON SHOTS, I UNDERSTAND THAT CHATTANOOGA PEDS RESERVES THE RIGHT TO DISMISS THE FAMILY FROM THE PRACTICE*.**
- IF MY FAMILY CHANGES PRACTICES, CHATTANOOGA PEDS RESERVES THE RIGHT TO NOT ACCEPT US BACK IN THE PRACTICE.
- **I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS AND ASSIGN AND REQUEST PAYMENT DIRECTLY TO CHATTANOOGA PEDS**
- **I AUTHORIZE CHATTANOOGA PEDS TO EMAIL MY STATEMENTS AND LEAVE MESSAGE ON MY PHONE.**
- **THESE POLICIES AND PROCEDURES ARE SUBJECT TO CHANGE**

_____ _____

Parent/Legal Guardian Signature Print Name

Date:_____