HEALTH INFORMATION PRIVACY

This document is to protect the privacy of your child' health information. Please fill it out completely and accurately.

The following people have my permission to bring my child to the office for medical examinations and treatment, including immunizations and injections:

_____ _____

_____ _____

_____ _____

1. May we discuss your child's medical information with anyone other than yourself? YES NO
   If yes, whom? Name _____ Phone # _____

2. May we contact you at home to confirm appointments and/or give you test results or other communications? YES NO

3. If you are not available at home, may we leave a message on your voicemail or with anyone answering the phone asking you to call our office? YES NO

4. May we contact you at work to confirm appointments or give you test results or other communications? YES NO

I acknowledge that Meade County Pediatrics, PLLC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information. I also acknowledge that the above information is true and accurate.

Signature _____ **Date** _____

Printed Name _____

Insurance Information

Primary Insurance:_____

Subscriber's Name:_____SSN:_____

DOB:_____Policy ID No.:_____Group No.:_____

Secondary Insurance:_____

Subscriber's Name:_____SSN:_____

DOB:_____Policy ID No.:_____Group No.:_____

Patient Financial Responsibilities

It is your responsibility to give our office current and up-to-date information. This includes any changes in name(s), address(s), and telephone number(s), as well as new insurance information.
It is your responsibility to know your insurance plan's policies and guidelines. Every insurance company is different.
It is your responsibility to contact your insurance company to verify that our physician is a participating physician with your insurance company and with your specific plan.

1. I authorize Meade County Pediatrics to initiate and maintain all medical/surgical treatment of my child/children in an emergency of life threatening situation until proper notification can be given and consent obtained.

2. RELEASE OF INFORMATION – I authorize release of any medical information necessary to file any claims to my insurance carrier. This signature or photocopy thereof irrevocably authorized the release of information necessary to process and insurance claim and further authorized payment of medical benefits to the physician providing services. ***In order to assist you with your insurance company, our office will be glad to submit your claim to your insurance company for you.***

PARENT/LEGAL GUARDIAN SIGNATURE SSN

FINANCIAL POLICIES

At the present time, we participate with most insurance companies. However, it is impossible for us to know what each individual insurance policy will or will not cover. For example, some Humana plans pay for preventive "well" visits while some cover only a portion of the visit, and others none at all. Some policies require a co-payment and/or co-insurance, while others do not.

If we do not participate with your insurance company, we will be happy to see your child "out of network". This may mean a reduction in your benefits. Since every insurance company has different rules, it is impossible for our staff to know what your insurance will pay. Please check with your insurance company or your human resource department.

Fees/Charges-A charge of $25.00 will be added to your account if your check is returned.

We will accept cash, check, money order, VISA, Master Card, or Discover. If needed, we are eager to work with you on a payment plan as long as your intent to pay is evident to us.

There will be a $30.00 fee for specialized forms that are filled out such as FMLA paperwork.

We value all of our patients and hope to build mutual trust and respect. Our financial policies were established to preserve the doctor/patient/family relationship. We ask that if there are extenuating circumstances regarding your account, that you call us immediately so that we can help you. Thank you for choosing Meade County Pediatrics.

I have read and understand the financial policy of Meade County Pediatrics and agree to these terms.

Signature Date