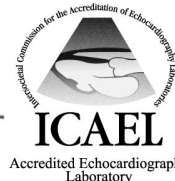




Children's Cardiovascular Medicine P.C



PATIENT INFORMATION

Last name _____ First Name _____ MI _____ DOB _____
Home Address _____
City _____ Zip _____ Phone _____

REFERRING PHYSICIAN

Name: _____ Phone _____ FAX: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone _____ FAX: _____

DOB & SS NUMBERS ARE REQUIRED FOR BILLING AND INSURANCE PURPOSE ONLY

FATHER'S INFORMATION. Is he the child's legal guardian? Yes ___ No ___

Last Name _____ First Name _____
Social Security # _____ DOB _____
Business Phone: _____ Cell Phone: _____
Home Address _____
City _____ Zip _____ Phone _____

MOTHER'S INFORMATION. Is she the child's legal guardian? Yes ___ No ___

Last Name _____ First Name _____
Social Security # _____ DOB _____
Business Phone: _____ Cell Phone: _____
Home Address _____
City _____ Zip _____ Phone _____

GUARDIAN'S INFORMATION. (If different from the above)

Last Name _____ First Name _____
Social Security # _____ DOB _____
Business Phone: _____ Cell Phone: _____
Home Address _____
City _____ Zip _____ Phone _____

EMERGENCY CONTACT

In case of emergency contact: _____
Phone: _____ Relation _____
Allergies/ Special Considerations: _____

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other Medical and/or Hospital procedures as may performed or prescribed by the attending physicians of Children's Cardiovascular Medicine P.C. for my child.

I give my consent to allow the adults listed below to bring my child to *Children's Cardiovascular Medicine P.C.* For care.

By listing the adults below I authorize the staff of *Children's Cardiovascular Medicine P.C.* to disclose protected health information at the time of the visit as needed to facilitate the medical care of my child.

Name	Relationship to Child	Phone Number

PARTY RESPONSIBLE FOR PAYMENT.

Relation to the patient: (circle one) Mother Father Guardian Other
Last Name _____ First Name _____
Social Security # _____ DOB _____
Business Phone: _____ Cell Phone: _____
Home Address _____
City _____ Zip _____ Phone _____

INSURANCE INFORMATION (Mandatory)

Name of Insurance _____
Address /PO BOX _____ City _____ State _____ Zip _____
Phone # (1-800) _____ Phone # (____) _____
Insured's Name _____ DOB _____
Relationship to Patient _____
Policy ID # _____ Group # _____

The parent and/ or legal guardian, who bring the child in for Medical services, will be required to pay the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.

_____ Initial. I have read and agreed to the above statement.

IF YOU HAVE A NEW BORN

Has the baby been added to your policy? YES _____ NO _____

All co-pays are due at the time of service.

All professionals' services rendered by *Children's Cardiovascular Medicine* are charged to the patient. The necessary insurance forms are filled for the patient claim processing and payment for services rendered. The patient's guarantor is responsible for all charges regardless of insurance coverage.

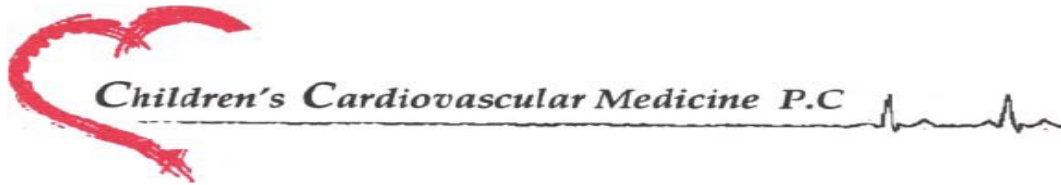
INSURANCE COVERAGE AND ASSIGMENT: I request that all insurance benefits be paid directly to *Children's Cardiovascular Medicine*. I permit a copy of the authorization to be use in place of the original and request payment be paid to this provider. I understand it is mandatory to notify my provider of any other insurance responsible for paying for treatment (section 1128B of the Social Security Act and 31 USC provides penalties for withholding this information).

Parent/guardian name (Please print) _____

Parent/Guardian signature _____ Date _____

I have read and understand the Notice of Privacy Practices: _____

Signature



**PATIENT CONSENT FOR
USE AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION**

With my consent, **Children's Cardiovascular Medicine** may use and disclose protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Children's Cardiovascular Medicine's** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Children's Cardiovascular Medicine reserves the right to revise its Notice of Privacy practices at anytime.

A revised Notice of Privacy practices may be obtained by forwarding a written request to **Children's Cardiovascular Medicine**, Privacy Officer at 61 Witcher St., Suite 4140, Marietta, Georgia 30060.

With my consent, **Children's Cardiovascular Medicine** may call my home or other designated location and leave a message on voice mail or in person in reference to any items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Children's Cardiovascular Medicine** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Children's Cardiovascular Medicine** may e-mail my appointment reminder cards and patient statements. I have the right to request that Children's Cardiovascular Medicine restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

By signing this form, I am consenting to **Children's Cardiovascular Medicine's** use and disclose of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Children's Cardiovascular Medicine** may decline to provide treatment to me.

Signature of Patient /Parent or Legal Guardian

Date

Patient's Name

Print Name of Parent or Legal Guardian

Children's Cardiovascular Medicine, PC
Financial Agreement and Policies
We verify eligibility and request an Insurance card

FINANCIAL POLICY / INSURANCE SUBMISSIONS

Payment in full is required at the time of service for all past due balances, deductible amounts that have not been met, non-insured patients and any coverage that could not be verified at the time of service. As the parent and/or guarantor you are required to pay the co pay/coinsurance at the time of service. Claims are billed to the insurance carrier; however, you are responsible for payment of all charges incurred. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to refund you for any payments made by you after your insurance company has paid in full.

Please Note: If you have changes to your insurance information, please notify our office immediately. Children's Cardiovascular Medicine, PC will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit.

Secondary Insurance

We do not bill secondary insurance unless your secondary is Medicaid, Wellcare, Peach State, Peachcare or Amerigroup.

_____ **Initial- I have read and agreed to the above statement.**

Returned Checks

All checks returned for insufficient funds, closed accounts, or for any other reason will be subject to a \$25.00 service charge. All further payments must be made either by credit card, money orders or cash.

_____ **Initial- I have read and agreed to the above statement.**

Deductibles and Co pays

Deductibles and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-pays and deductibles in order to participate with their plans.

_____ **Initial- I have read and agreed to the above statement.**

Divorce/Custody

The parent and/or guarantor who is bringing the child in for medical services will be responsible for any payments due at the time of service. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.

_____ **Initial- I have read and agreed to the above statement.**

Collection/Late Fees

We charge a one-time \$15.00 collection fee and a 1.5% per month rebilling/late fee on patient balances not paid in full within 60 days from the date the charge is turned over to patient responsibility. Balances are turned over to patient responsibility once insurance has processed the claim and determined patient responsibility. Balances will also be turned to patient responsibility if insurance is unable to process claims due to missing or incomplete information not provided by policy holder to their insurance company. This will be reflected on our monthly statements.

_____ **Initial- I have read and agreed to the above statement.**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We would be willing to discuss reasonable payment plans. If you have any question about the above information, or any uncertainty regarding your insurance coverage, **PLEASE** do not hesitate to ask us.

I authorize Children's Cardiovascular Medicine, PC to release any medical or other information to the insurance carrier which may be necessary to process the claims. I authorize my insurance carrier to pay the provider of service.

Parent/Legal Guardian Name (Please Print)

Patient's Name

Parent/Legal Guardian Signature

Today's Date