Patient Information: (Please fill out every field completely. Circle Items in blue.)

Child's first Name:		I II III IV V
Last Name:		Jr Sr
Mailing Address:		Date of Birth:
Address line 2:		SSN:
City, State:		Phone Number:
Zip Code:		
Sex: M F		Who does the child live with?
Email Address:		Father Mother Both Parents Other

Parent/Legal Guardian Information

Father's Name:		I II III IV V
Last Name:		Jr Sr
Mailing Address:		Date of Birth:
Address line 2:		SSN:
City, State:		Phone Number:
Zip Code:		
Sex: M F		Relationship to patient:
Email Address:		

Mother's firstName:		I II III IV V
Last Name:		Jr Sr
Mailing Address:		Date of Birth:
Address line 2:		SSN:
City, State:		Phone Number:
Zip Code:		
Sex: M F		Relationship to patient:
Email Address:		

Insurance information: (Please provide current insurance card to the clinic.)

Insurance Name:	Insurance Phone:
Subscriber name:	Subscriber DOB:
Member ID:	
Group Name/Employer:	Group ID Number:
Relationship to Subscriber: Self Spouse Child Other:	
Reason For Visit:	

I authorize release of my information in the event of an emergency to the following person: (If none, leave blank.)

Emergency Contact Name:	
Emergency Contact Phone:	
Any Restrictions:	
Relationship:	

**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the clinic.*

HIPPA PROTECTED HEALTH INFORMATION

I understand that state and federal laws permit HALLSVILLE MEDICAL CLINIC to share Protected Health Information with the persons involved in my care or the payment of my health care services. I further understand that I have (I) the right to grant certain persons access to my PHI and (II) the opportunity to restrict access to my PHI from certain persons who might otherwise have access. I understand that granting access DOES NOT give the person access to copies of my medical records.

I grant permission for the following persons to have access to my Protected Health Information.

NAME:	DOB:	PHONE NUMBER:

I understand that I may change or revoke this form at any time by contacting the Business Office Manager at the Hallsville Medical Clinic. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

YES or NO You may leave confidential clinical information on my answering machine/voicemail.

CONSENTS AND AGREEMENTS SIGNATURE

I UNDERSTAND THAT THE FOLLOWING PACKETS OF PAPERWORK WERE MADE AVAILABLE TO ME TO REVIEW BEFORE AND AT MY INITIAL NEW PATIENT VISIT. MY SIGNATURE BELOW INDICATES MY AUTHORIZATION OF THESE POLICIES IN REGARD TO MY MEDICAL TREATMENT. I CAN REQUEST A COPY OF ANY/ALL OF THESE DOCUMENTS AT ANY TIME, AND I AM AWARE THEY ARE ALSO AVAILABLE FOR REVIEW ON WWW.HALLSVILLEMEDICALCLINIC.COM

- PATIENT CONSENT – (GIVING CONSENT TO RECEIVE TREATMENT AT THE CLINIC LOCATION, RELEASE/ACQUISITION OF INFORMATION, HEALTH INFORMATION EXCHANGE, HIPPA NOTICE OF PRIVACY PRACTICES)
- PATIENT AUTHORIZATION – (ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, AUTOMATED COMMUNICATIONS, OUTPATIENT DEPARTMENT)
- FINANCIAL POLICY – (AGREEMENT OF FINANCIAL RESPONSIBILITY, THE CLINIC'S RIGHT TO COLLECT PAYMENT FOR SERVICES, AND TO BILL INSURANCE IF ALLOWABLE)
- CLINIC CARE CONSENT – (GENERAL CONSENT, PERSONAL PROPERTY, RIGHTS AND ADVANCE DIRECTIVES, FINANCIAL ASSISTANCE, RELEASE OF INFORMATION, MEDICARE/MEDICAID BENEFITS, COMMUNICATIONS, ACCIDENTAL EXPOSURE AND STATE REPORTING, OWNERSHIP, PHOTOGRAPHY, ETHICS, TEACHING AND OBSERVATION, NOTICE OF PRIVACY PRACTICES, DIRECTORY, ASSIGNMENT OF BENEFITS, INSURANCE NETWORK, BALANCE BILLING DISCLOSURES)

(Requests for these documents can be made by email to hmc@hallsvillemedicalclinic.com or in person.)

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents and agree to the terms. I acknowledge that I am the patient, or I am the patient's legally authorized representative and/or Guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature: ______________________________ Date: ______________________

(Signature of parent/guardian/responsible party.)

Printed Name: _______________________ Relationship to Patient: __________

Pediatric Medical Questionnaire

Name (last, first, middle initial):____
Birth date: _____/_____/______ Age: ______________ Sex: M F

Medical History: Please list any medical problems your child has, take medications for, or has had in the past.

____

____

____

Pregnancy: Was the child full term? Y N How many weeks?__________
Did your child come home from the hospital with Mom? Y N If not, why?______________
Complications during pregnancy: ______________________________
Problems during the first week of life: ______________________________
Birth weight:______________Birth Head Circumference:______________ Birth Length:__________
Immunizations: Please give us copy of your child's immunizations
Current Medications:

Medication Name	*Dosage (mg)*	*# times per day*	*Medication Name*	*Dosage (mg)*	*# times per day*

Surgical History:

Surgery	*Date*	*Surgery*	*Date*

Hospitalizations:

Reason for Hospitalization	*Date*	*Reason For Hospitalization*	*Date*

Allergies: Please list any drug, food, or contact allergies ______________________________

____

Social History:
[ ] Exposure to Tobacco
Does your child eat a balanced diet? Y N [ ] Breast Fed [ ] Bottle fed. Type of Formula: ______________
Appetite [ ] good [ ] poor. What types of food does your child eat? ______________________

Family History:
Mother: Age _____ Living [ ] Medical problems: ______________________________
Deceased [ ] Cause of Death: ______________________________
Father: Age _____ Living [ ] Medical Problems: ______________________________
Deceased [ ] Cause of Death: ______________________________
Number of siblings______Medical Problems: ______________________________
Do any members of your family have? (Parents, siblings, children, grandparents)

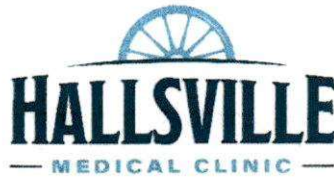
[ ] Allergies [ ] Diabetes [ ] High Blood Pressure [ ] Seizures
[ ] Anemia [ ] Glaucoma [ ] High Cholesterol [ ] Bleeding disorders
[ ] Cancer [ ] Heart Problems [ ] Kidney Problems [ ] other inherited diseases

Review of Systems: Has your child had any of the following problems in the past month?

[ ] Skin Problems [ ] Frequent Ear Infections [ ] Abdominal Pain [ ] Foot or Leg Problems
[ ] Headaches [ ] Frequent Colds [ ] Excessive Colic [ ] Joint/bone pain
[ ] Head Injuries [ ] Neck Lumps [ ] Nausea/Vomiting [ ] Weakness
[ ] Loss of Consciousness [ ] Cough [ ] Diarrhea [ ] Seizures
[ ] Visual Problems [ ] Wheezing [ ] Constipation [ ] Sleeping Problems
[ ] Sinus Problems [ ] Shortness of Breath [ ] Change in Bowels [ ] Nervousness/anxiety
[ ] Nose Bleeds [ ] Chest Pain [ ] Burning with Urination [ ] Depression
[ ] Seasonal Allergies [ ] Heart Murmurs [ ] Blood in urine [ ] Problems in School
[ ] Hearing Problems [ ] Feeding Problems [ ] Skin rashes

Development/Behavior:
As far as you know is your child's development normal? Y N
At what age did you child do the following: Hold head steady________Sit Up________Crawl_________Talk__________
Walk_________Potty Train____________

Do you have any other concerns about your child?______________________________



Patient Financial Policy

Thank you for choosing *Hallsville Medical Clinic* for your healthcare needs. We want to provide you with quality healthcare and a clear understanding of our Patient Financial Policy is vital to that relationship. Please ask if you have questions regarding our fees, policies, or your responsibilities.

______**INSURANCE** – We participate in some but not all insurance plans. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- If you are insured by a plan, we are credentialed with but don't have an up-to-date insurance card, or the benefits can't be verified, payment in full for the visit is required.
- If you are not insured by a plan, we are credentialed with payment in full is required at each visit, or you may request to be seen as a self-pay patient to have access to our reduced fee schedule. A claim will not be generated or filed in this situation.

______**COPAYMENTS AND DEDUCTIBLES** – All copayments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company.

- Failure for our office to collect, or for the patient to pay copayments/deductibles can be considered fraud.
- To make payments convenient we accept VISA, MasterCard, American Express, Discover, Care Credit, Cash, local checks.
- Please complete the Credit Card Authorization form attached.

______**NON-COVERED SERVICES** – Please be aware that some or all of the services you receive may not be covered by your insurance plan. You will be required to pay for these services in full.

______**PROOF OF INSURANCE** – All patients must complete all patient information forms before receiving healthcare services.

- We will need to obtain a copy of your driver's license and current valid insurance to provide proof of coverage.
- If you fail to provide us with the correct insurance information/identification, or order of coverage in the case of multiple policies, in a timely manner you will be responsible for the unpaid portion of the claim filed. Be sure to coordinate benefits with your insurance carriers so that you know which plan is primary and which is secondary.

______**CLAIM SUBMISSIONS** – We will submit claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests.

- The balance of your claim is your responsibility regardless of if your insurance company pays the claim.

______**COVERAGE CHANGES** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive maximum benefits. It is the policy holder's responsibility to provide our office with correct and current information for filing claims.

- If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

______ **NON-PAYMENT** – It is our office policy that all past due accounts be sent 2 statements. If payment is not made on the account a single phone call will be made to collect the debt.

- If no resolution can be made the account will be sent for collection and could result in being discharged from the practice.

_____ **MINORS** – (less than 18 years of age)

- The parent or guardian is responsible for full payment and will receive a call from the office to make a payment over the phone if the minor presents without payment for the services.
- A signed release to treat a minor in the absence of the parent/guardian is required.

______**SELF PAY ACCOUNTS** – Self pay accounts are for patient's without insurance coverage, patients with insurance plans in which the office does not participate, or patients without an insurance card on file.

- If a patient presents a self-pay status it is understood that an insurance claim will not be submitted to an insurance company.

Patient/Guarantor Signature ______________________________ **Date** ____________

Witness ____ **Date** ____________

My initials and signature are evidence that I have read, understand, and agree with the financial policy of the Hallsville Medical Clinic.

CREDIT CARD AUTHORIZATION FORM

Credit Card Information
MasterCard VISA Discover AMEX CareCredit OTHER:
Card Number:
Expiration Date (mm/yy): CVC :
Cardholder ZIP Code (from credit card billing address):
I, ________________________________ , authorize *Hallsville Medical Clinic* to charge the credit card above for the balance owed for the purchase of medical services. I understand that my information will be saved to file for future transactions on my account.
Customer Signature: Date:
Witness Signature: Date:

By signing this form, you, the patient or responsible party, give permission to Hallsville Medical Clinic to process payment for services provided and fees associated with the collection process. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled.