Gastro Health for Kids
Delivering Clinical Excellence

Patient Information:
Name: _____
DOB:_____ Place of Birth:_____ SS#:_____
Sex: ☐M ☐F Race/Ethic Origin:_____ Marital Status: ☐M ☐S ☐D ☐W

Mailing Address: _____
Home Telephone: _____ Cell Telephone: _____

Email Address: _____

Employment Information:
Place of Employment: _____
Work Telephone: _____ Occupation: _____

Spouse/Patent Guardian Information:
Name: _____
DOB: _____ SS#:_____ Relationship: _____
Work Telephone: _____ Occupation: _____

Insurance Information:
Primary Insurance: _____ ID#: _____ Group #: _____
Policyholder Name: _____ DOB: _____ Relationship: _____
Secondary Insurance: _____ ID#: _____ Group #: _____
Policyholder Name: _____ DOB: _____ Relationship: _____

If parents are divorced or separated please fill out this section:
Who has custody? _____ Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
_____

Emergency Contact:
Name: _____ Relationship: _____
Home Telephone: _____ Work: _____ Cell: _____

Pharmacy Name: _____ **City/State: _____** **Phone: _____**

PCP NAME ---------- **Phone**----------

Please read and Initial for each of the following:

_____: **All Co-pays and Self Pays are due at time of services unless previous arrangements made prior to office visit or proxcedure.**

I consent to treatment necessary for the care of the above named patient. I certify that information provided by me in applying for payment under the Title XVIII of the Social Security act or by my insurance is correct. I authorize any holder of medical or other information about me to release to Medicare, Medicaid, or any insurer information needed for this or any other claim. I authorize release of my medical information to referring or other physicians and to my insurer by mail or fax. I request that payment of authorized benefits be made on behalf of me to my provider of services. I understand that I am personally financially responsible for fees associated with services not covered by my insurer. I agree to pay all responsible attorney fees and collection costs in the event of default of my payment of charges. I have read and fully understand the above consent, financial responsibility and information release statement.

_____ _____
Signature of Patient/Parent or Guardian Date

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Consent to obtain Electronic Medication History:

I understand that my medication history may be obtained utilizing an electronic information exchange that this protected health information may provide valuable information for my healthcare provider..
I hereby authorize Gastro Health for Kids to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Date: ---------- Patient's/Guardian Signature: _____

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Patient Record Disclosure

In general, the HIPAA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI). The individuals is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosures of and request for PHI to minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

When disclosing a person name this means that the person below can access all your information which includes appointments, medical information, medications.

Date: _____ Disclose to Whom: _____

Telephone:_____ Description of disclosure: _____

Notice of Health Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Private Health Information (PHI) will be used for the purpose of treatment, payment, or healthcare operation only (writing prescriptions, planning menus, and mailing out bills.)

For Example:

1. Information that identifies you will be entered in your record ad used to determine the course of treatment that should work best for you, and your health care team will use this record to document the actions they took and their own observations.

2. A bill sent to you or third party payer may include information that identifies you, your diagnosis, procedures, and supplies used.

3. The quality improvement team may use information in your health record to access the care and outcomes in your case and others like it and use this information in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

PHI may be disclosed to another Healthcare Provider for treatment and payment activities of the other Healthcare Provider. PHI may also be disclosed to another Healthcare Provider for its Healthcare Operations if:

1. The Healthcare Provider has or has had a relationship with the patient who is the subject of the PHI
2. The PHI pertains to that relationship
3. The disclosure is for the purpose of either conducting quality assessment or improvement activities, reviewing the competence or qualifications of healthcare professionals, or for detecting fraud and abuse or complying with the same.

PHI may cause used for the following: (If the patient objects to any of the uses listed below, Please cross them out.)

1. Contact patients to remind them of appointments
2. To give information about treatment alternatives of other health related benefits and services
3. Contact patients to raise funds for the hospital
4. Facility Directories
5. Research studies conducted by medical staff and allied health staff.
6. Notification of family member, other relative or close personal friend of health information relevant to that person's involvement in your care or payment related to your care.

I have received a copy of the Notice of Privacy Practice of Gastro Health for Kids on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted at the hospital.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future, or if I have any questions with regard to Notice of Privacy Practices, I may contact:

_____ _____

Print Patient Name Date

_____

Signature of Patient/Parent of Guardian

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment,

as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician._____ (initials)

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**
In consideration of services rendered, I hereby transfer and assign to Gastro Health for Kids all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. _____ (initials)

3. **FINANCIAL AGREEMENT T**he undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency for collections, the undersigned should pay reasonable fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS. _____ (initials)

It is your responsibility to contact your insurance to confirm that our physician participates in your plan and you understand the benefits _____(initial)

In cases of divorce or separation, the parent authorizing treatment/services for the minor patient will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the charges, it is the authorizing parent's responsibility to collect from the other parent. Neither GHK nor its affiliates will mediate payment between parents----------(initial)

4. If you do not have health insurance, or we do not have a contract with your insurance, you will be responsible for payment of services rendered.---------- If you are not able to make the minimum payment at check-in, you will be asked to reschedule your appointment ----------(initial)

5. You can expected to receive the following bills as a result of the patient's visit or procedure:
Physician Fee: Fee to be paid to the physician for performing the service such as a procedure or office visit. This bill will be from Gastro Health for kids
Lab Fee: If a lab test is ordered, a second bill will come from a lab or a radiologist. Facility fee: billed by the facility for procedure performed such as an egd and colon----------(initial)

6. In providing us with your credit card information, you are giving Gastro health for kids permission to automatically charge your credit card on file for your co-pay, deductible or outstanding balances on file as well as any no show fees. at the time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request. . _____ (initials)

7. MEDICARE / MEDICAID Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _____ (initials)

8. RETURNED CHECK CHARGE: If we receive a returned check from your bank due to non-sufficient funds, account closed, etc. you will be charged an administrative fee of $35.00. This fee and any balance due will need to be paid by you prior to your next appointment. Please note that this is not covered by your insurance. _____ (initials)

9. COLLECTIONS ON ACCOUNTS: If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and patient will be dismissed from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. If your account is placed with a collection agency due to non-payment for any guarantor balances, you will be responsible for any costs associated with these collection efforts. Possible cost could include collection percentage for outside company fees and attorney/court fees that may apply. It is important that you communicate with our billing department if payment arrangements need to be made. _____ (initials)

10. COMPLETION OF FORMS: Please note that there is a $25.00 minimum charge for the completion of all paperwork, including FMLA, Homebound, short term and long term disability paperwork. Payment will be collected at the time paperwork is received in our office. Paperwork will be completed as quickly as possible, and our office will call you when it is completed. FLMA, Short Term, Long Term Disability paperwork $35.00, Homebound paperwork $25.00. _____ (initials)

11. NO SHOW POLICY: If you have an appointment with our office and are unable to attend, you must give our office 48-hour notice so that we may give the appointment to another needy child. In the event that 48-hour notice cannot be given, please give our office a call as soon as possible**. If we do not receive a call within 24 hours prior to your scheduled appointment, you will be responsible for a $25.00 No Show Fee. If you had a procedure scheduled and do not call 48-hours prior to the procedure, you will be responsible for a $50.00 No Show Fee for the procedure. These are not covered by your insurance and must be paid before the next visit. After**

the third missed appointment, we will no longer be able to offer medical care for your child._____ (initials)

DATE: _____GUARDIAN/ PATIENT'S SIGNATURE:_____

Patient Credit Card on File Agreement

Preauthorized Credit

We have implemented a policy which enables you to maintain your credit card information securely on file with _____. In providing us with your credit card information, you are giving _____ permission to automatically charge your credit card on file for your co-pay, deductible, coinsurance or outstanding balance including no show fees etc. at the time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays, Deductible outstanding balances etc.*:* Co-pays & deductible (not met) are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, _____will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize _____, to charge co-pays and outstanding balances on my account to the following credit card:

American Express ☐ VISA ☐ Mastercard ☐

Credit Card Holder's Name: ----------
Card number _____ CVV number: _____
Expiration Date: _____

Patient Signature: _____ Date ----------