Patient Registration & Consent

Fort Payne Pediatrics

Is this your first visit to this office? ☐Yes ☐No
How did you hear about us? ☐Facebook ☐Instagram ☐Google ☐Family/Friend: _____

Patient's Legal Name: _____
Last First Middle

Address: _____
Street Apt #

_____
City State Zip

Date of Birth: _____ SS #: _____

Home Phone: (____)_____ Cell: (____) _____

Email: _____

PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian: _____

Date of Birth: _____ SS#: _____

Address (if different): _____

_____

Home Phone: (____)_____ Cell: (____) _____

Parent/Legal Guardian: _____

Date of Birth: _____ SS#: _____

Address (if different): _____

_____

Home Phone: (____)_____ Cell: (____) _____

Siblings & DOBs: _____ _____ _____

We are required to collect the following information for each patient.

Please complete this section before returning the form.

Preferred Doctor/CRNP:

_____

Your preferred language:

_____

Sex (Circle): M☐ F☐

Your child's Race/Ethnicity:
(select one primary)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other
- ☐ Decline to answer

PRIMARY INSURANCE INFORMATION

Plan Name: _____ Policy ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS #: _____

Patient's Relationship to Policy Holder: _____ Copay: ☐Y ☐N Amount: _____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ Policy ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS #: _____

Patient's Relationship to Policy Holder: _____ Copay: ☐Y ☐N Amount: _____

I agree that the above information is true and correct to the best of my knowledge. **If over the age of 14, the patient MUST sign this form.**

_____ _____ _____
Print Name (Patient or Guardian if under 14) Signature (Patient or Guardian if under 14) Date

_____
Relationship to Above Patient

Delegation of Consent for Minor Children & Acknowledgment of Receipt of Privacy Practices

I, _____, authorize Fort Payne Pediatrics, LLC and its personnel to deliver
Print Name (Patient or Guardian if under 14)
any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama to me and/or child(ren) listed below. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This authorization shall be valid until I withdraw my delegation of consent.

(Please Print)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

The following section must be completed if the patient is under the age of 14:

I, _____, authorize the following people to bring my child(ren) in for
Print Name of Biological Parent or Legal Guardian
treatment and to consent to any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent.

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Please note: If the patient is under the age of 14, the individuals listed above are the **ONLY** people (other than biological parents or legal guardians) authorized to bring your child(ren) to the doctor.

I have reviewed this office's Notice of Privacy Practices which explains how my or my child(ren)'s medical information will be used and disclosed, and/or I understand that I am entitled to receive a copy of this document upon my request. Furthermore, I agree to receive calls, detailed messages, or correspondence about my or my child(ren)'s appointments, lab and x-ray results, or other health care information at the address and phone numbers listed on Page 1 of this Patient Registration form. **If over the age of 14, the patient MUST sign this form.**

_____ _____
Print Name (Patient or Guardian if under 14) Relationship to Patient

_____ _____
Signature (Patient or Guardian if under 14) Date

_____ _____
Witness Translator/Reader (If Applicable)

Fort Payne Pediatrics	Patient's Name:
1359 Old Water Works Rd SW	Mom's Name:
Fort Payne, AL 35968-3347	Dad's Name:

ALLERGIES – Please list the **patient's** drug, food, or other allergies:

☐ No known drug allergies Or, list drug allergies:
☐ No food or other allergies Or, list food/other allergies:

MEDICATIONS – Please list all of the patient's medications and supplements:

Medication Name	**Dose**	**Medication Name**	**Dose**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PAST MEDICAL HISTORY – List the **patient's** medical conditions:

1.	5.
2.	6.
3.	7.
4.	8.

PAST SURGICAL HISTORY – List the **patient's** previous surgeries and approximate dates:

Operation	**Date**	**Operation**	**Date**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

FAMILY MEDICAL HISTORY - Please check and list relationship to patient, include **immediate family** members only:

☐ Lung Disease _____

☐ Heart Trouble _____

☐ Kidney or Bladder Disease _____

☐ Diabetes _____

☐ High Blood Pressure _____

☐ Cancer - Type of Cancer and Affected Family Member(s) _____

☐ Other Family Disease _____

BIRTH RECORDS

Birth Facility: _____

Facility City: _____ Facility State: _____

The following information MUST match birth records:

Patient Date of Birth: _____

Patient's Name (First Last): _____

Birth Mother's Name (First Last): _____

Birth Mother's Social Security Number: _____

IMMUNIZATION HISTORY

Please attach a complete shot record.

If you do not have a complete shot record, please list all facilities where the patient has received immunizations:

_____

_____

_____

_____

_____

Notice of Privacy Practices

Fort Payne Pediatrics

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at Fort Payne Pediatrics (hereafter "FPP") may be billed to and payment may be collected from you, an insurance company, or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at FPP or the hospital. For example, we may disclose medical information about you to people outside FPP who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run FPP and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other FPP personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes FPP's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other FPP personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at FPP. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by FPP, whether made by FPP personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. A request form may be obtained at the front desk. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, FPP. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. A request form may be obtained at the front desk. We may deny your request for an amendment.

Right to Request Removal from Fundraising Communications: You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan: You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which you have paid out of pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted. A request form may be obtained at the front desk.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. A request form may be obtained at the front desk.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. A current copy will be available at the front desk.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with FPP or with the Secretary of the Department of Health and Human Services. To file a complaint with FPP, contact Jessica Cushen, (256) 997-5900, 1359 Old Water Works Rd SW, Fort Payne, AL 35968-3347. All complaints must be submitted in writing. A complaint form is available upon request. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

Signature of Patient/Guardian: _____ Date: _____

A. Access to Care

Individuals shall be afforded impartial access to treatment that is available and medically indicated, regardless of race, creed, sex, national origin, religion, sexual orientation, disability or source of payment. Free translation services are available.

B. Respect and Dignity

The patient has the right to considerate, respectful care at all times, under all circumstances, with recognition of his personal dignity and worth.

C. Privacy and Confidentiality

The patient has the right, within the law, to personal privacy and information privacy, as manifested by the right to:

1. Refuse to talk with or see anyone not officially connected with the clinic, including visitors, persons officially connected with the clinic but who are not directly involved in his care.
2. Wear appropriate personal clothing and religious or other symbolic items, as long as they do not jeopardize safety or interfere with diagnostic procedures or treatment.
3. To be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own gender present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex; and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
4. Expect that any discussion or consultation involving his/her case will be conducted discreetly and that individuals, not involved in direct care, will not be present without permission of the patient.
5. Have his/her medical record read only by individuals directly involved in treatment or monitoring of quality, and by other individuals only on written authorization by the patient or that of his/her legally authorized representative.
6. Expect that all communications and other records pertaining to his care, including the source of payment for treatment, be treated as confidential.
7. Expect that information given to concerned family members or significant other legally qualified person, be delivered in privacy and with due consideration of confidentiality.
8. Request transfer to another available room if another patient or visitors in that room are unreasonably disturbing to said patient.
9. Be placed in protective privacy and/or be assigned an alias name when considered necessary for personal safety.

D. Personal Safety and Security

The patient has the right to expect reasonable safety in so far as the clinic practices and environment are concerned. To address the needs of patient, visitor and staff regarding safety and security, the University Police patrol 24 hours per day and are present in the Emergency Room around the clock. Other safety and security measures include limited access to the facility through the use of electronic access cards and readers on exterior entrances, video monitoring in numerous areas of the campus, and the use of employee identification badges that are to be conspicuously displayed.

E. Identity

The patient has the right to know the identity and professional status of individuals providing service and which physician or other practitioner is primarily responsible for his care. This includes the patient's right to know of the existence of any professional relationship among individuals who are treating him, as well as the relationship to any healthcare or educational institutions involved in his care. Participation by patients in research programs, or in the gathering of data for research purposes, shall be voluntary with a signed informed consent.

F. Information

1. The patient has the right to obtain from the practitioner responsible for coordinating his care, complete and current information concerning his diagnosis (to the degree known), treatment, pain management, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information shall be made available to a legally authorized individual.
2. The patient has the right to formally access his medical records. The patient shall complete the Authorization to Disclose Protected Health Information (form #1148) which is then sent to Health Information Management for processing. The Manager/Charge Nurse is to be notified when such requests are made.
3. The patient may access, request an amendment to, and/or receive an accounting of disclosures of their own protected health information as permitted under applicable law.

G. Communication

1. The patient has the right of access to people outside the clinic by means of visitors, and by oral and written communication. The patient may request not to be included in the patient directory. Inclusion in the patient

directory means that the patient's name; room number and a general condition report may be given to people who ask about the patient by name.

2. The prisoner patient has the right to visitors only as approved by the warden of the prison or jail where the prisoner patient is incarcerated.
3. When the patient does not speak or understand the predominant language of the community, or is hearing impaired, he/she shall have access to an interpreter if at all possible. This is particularly true where language barriers are a continuing problem.

H. Consent

1. The patient has the right to reasonably informed participation in decisions involving his/her health care. To the degree possible, this shall be based on a clear, concise explanation of his/her condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient shall not be subjected to any procedure without his/her voluntary, competent, and informed consent, or that of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.
2. The patient has the right to know who is responsible for authorizing and performing the procedures or treatment.
3. The patient shall be informed if the clinician proposes to engage in or perform human experimentation or other research/educational projects affecting his/her care or treatment, and the patient shall sign an informed consent if participation is desired and maintains the right to refuse to participate or withdraw from any such activity at any time.
4. The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.
5. If a patient is unconscious or is determined to be mentally incompetent and no consent can be obtained from an appropriate family member, legal action may be taken to obtain a court order for diagnostic and therapeutic procedures. In life-threatening emergencies, where the patient is incompetent or unconscious, appropriate treatment may be administered without consent.

I. Consultation

The patient, at his/her own request and expense, has the right to consult with a specialist.

J. Transfer and Continuity of Care

1. A patient may not be transferred to another facility unless he/she has received a complete explanation of the need for the transfer and the alternatives to such a transfer, and unless the transfer is acceptable to the other facility. The patient has the right to be informed by the responsible practitioner or his/her delegate of any continuing healthcare requirements following discharge from the clinic.
2. Regardless of the source of payment for his/her care, the patient has the right to request and receive an itemized and detailed explanation of his/her total finalized bill for services rendered in the clinic. The patient shall be informed of eligibility for reimbursement by any third-party coverage during the admission or pre-admission financial investigation.

K. Clinic Rules and Regulations

The patient shall be informed of the clinic rules and regulations applicable to his/her conduct as a patient. The clinic's Notice of Privacy Practices is available from the Front Desk or can be found on the clinic website.

L. Complaint Process

The patient has the right to file a complaint regarding services and is entitled to information regarding the clinic’s mechanism for the initiation, review and resolution of such complaints.

M. Patient Responsibilities

Patients have the responsibility for:

1. Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health.
2. Following the treatment plan recommended by those responsible for their care.
3. Their actions if they refuse treatment or do not follow the healthcare team's instructions.
4. Seeing that their bills are paid as promptly as possible; following clinic rules and regulations.
5. Being considerate of the rights of other patients and clinic personnel.
6. Seeking information, and in the event they have questions, asking them.

Signature of Patient/Guardian: _____ Date: _____

PH: (256) 997-5900

FAX: (256) 997-5995

Fort Payne Pediatrics

Authorization to Release Protected Health Information

Patient Name (Last)	(First)	(MI)
Date of Birth	Social Security Number	
Street Address	State	Zip

☐ I, the undersigned, do hereby authorize Fort Payne Pediatrics LLC to **receive** the above-named patient's PHI **FROM**:

☐ I, the undersigned, do hereby authorize Fort Payne Pediatrics LLC to **release** the above named patient's PHI **TO**:

(Agency/Facility/Person)

(Street Address) (City/State) (Zip)

(Phone Number) (Fax Number)

Reason for transfer or release of PHI:

☐ Insurance Change ☐ Transfer of Care ☐ Legal

☐ Moving out of area ☐ Specialty Consultation ☐ Personal

Specific PHI to be transferred or released:

☐ Entire Medical Record ☐ Other: _____

I understand that the patient's entire medical treatment record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should NOT be released:

Specific information NOT to be released

Signature

✱There is a fee to release medical records to a legal parent or guardian. Per state law, you may be charged up to $1.00 for each page of the first 25 pages, $0.50 for each page in excess of 25 pages, and a search fee of $5.00 for each patient health record requested.✱

Release or transfer of the specified information to any person or entity not specified above is prohibited. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and mail my written revocation by certified mail, return receipt requested to the Privacy Officer at Fort Payne Pediatrics. I understand the revocation will not apply to information that has already been released in response to this authorization. I also understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once this health care information is released, redisclosure of it by the recipient may no longer be protected by law.

This authorization is valid until _____ or two years from the date signed. Only the records from the facility/agency/person listed above can legally be released. Any record from another physician must be obtained from them.

I understand I have a right to receive a copy of this request.

Patient/Parent/Legal Guardian Signature Relationship to Patient Date

I attest to the identity of the above signature(s):

(Print) Witness Name Witness Signature Date

If age 14 or older, patient should sign this form.

Financial Policy

Fort Payne Pediatrics

It is the policy of this office to help keep your health care costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Notify us of any changes in insurance, address, telephone, or family status at time of check-in.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan, and you will be 100% responsible for these charges. The following are your responsibilities:

- Ensure our providers actively participate with your insurance carrier.
- Know your and your dependents benefit coverage and verify your eligibility, prior to receiving services.
- Know your co-pay, coinsurance, and/or deductible amounts.
- Make sure that all individuals on your policy have the correct primary care physician selected at your insurance company as this is the number one reason why claims are denied.
- Ensure that all pre-authorization requirements are met to avoid denials or out-of-network benefits.
- You will be considered self-pay for the day's visit if:
    - You do not have insurance;
    - Our practice does not participate with your health plan;
    - You are unable to present a valid member identification card from your insurance carrier at your visit; or
    - We are unable to verify your insurance coverage.

INSURANCE BILLING: Remember that we must receive up to date billing information in order to meet the claims submission guidelines set by your insurance plan. If you fail to provide complete and accurate primary and/or secondary insurance information on the date of service, you will be held responsible for services rendered that day.

If we are not a participating provider with your insurance plan or if your insurance plan does not provide coverage for the provider you are seeing, you will be 100% responsible for all charges incurred and will be considered self-pay for all visits.

To summarize, you are financially responsible for

- Denied and non-covered services;
- Services deemed not medically necessary by your policy;
- Co-payments, deductibles, and coinsurance;
- Pended claims due to lack of patient or guarantor information.
- Non-Insurance and/or out-of-network benefits.

CO-PAYS: We are required by our insurance contracts to collect all co-pay and patient responsible amounts. Co-pays are due at the time of service. If you do not know your co-pay, we may request a deposit of $25.00 prior to your being seen by a physician.

DEDUCTIBLES: If you have not met your deductible, we may request a deposit of $90.00 prior to your being seen by the physician.

SELF-PAY PATIENTS: Self-pay patients are required to make a deposit of $90.00 during check-in. If additional charges are accrued during the visit, you must pay for the charges before leaving the office.

NON-EMERGENCY APPOINTMENTS: Well child visits, physicals, or any non-emergent follow-ups or visits may be rescheduled if outstanding balances, co-pays, or self-pay charges are not paid at the time of service.

RETURNED CHECKS: The current fee for returned checks is $30.00. We have the right to adjust the amount at any time.

CHILD CUSTODY: For any children seen, the accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital custodial disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent.

STATEMENTS: We will send monthly statements for charges that have been identified as your responsibility. Your monthly statement will separately list previous balances, any new charges to the account, and any payment or credits applied to your account during the month.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid within 30 days of the statement date.

COLLECTIONS: Failure to pay account balance in full within 30 days from statement date may result in a $5.00 rebilling fee to cover the cost of mailing additional statements. Any past due balances not paid after 120 days from initial statement date will be turned over to a collection agency. You will be responsible for any charges and fees resulting from this action. If your account should be forwarded to a collection agency, we will continue to see you on an emergency-only basis for 30 days, allowing you time to find a new source of medical care.

SLIDING FEE SCHEDULE: We offer discounted service rates for eligible patients who wish to apply. These rates are based upon your annual household income. To determine eligibility, we will need to see proof of identification and address, three most recent pay stubs, and evidence of Medicaid program rejection.

PAYMENT PLANS: We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for payment arrangements and assistance in the management of your account. We do offer a limited payment plan for those patients who need some flexibility, with the following criteria:

1. You will be required to provide us with a credit or debit card number to automatically process your payment on specified dates.
2. The balance must be paid in full within six months of the date of a signed payment plan agreement (unless otherwise specified).
3. A copy of this agreement will serve as your reminder. Regular statements will not be mailed for this balance.
4. No future charges may be added to this payment plan, as it is not intended to be a revolving charge account. Until the initial payment agreement is paid in full, all future visit costs will be due in full at the time of service.
5. If at any point you are unable to keep this payment agreement, and fail to notify Fort Payne Pediatrics, your account will be sent to a collection agency. If your account is forwarded to collections, you will be given 30 days to select a new primary care physician. During that 30-day period, we will continue to provide emergency-only medical care for your child.

COPIES OF MEDICAL RECORDS: Per state law, you may be charged up to $1.00 for each page of the first 25 pages, $0.50 for each page in excess of 25 pages, and a search fee of $5.00 for each patient health record requested.

I have read and understand Fort Payne Pediatrics Financial policy. I certify that I have provided Fort Payne Pediatrics with complete and accurate insurance coverage information, and I understand that I am financially responsible for all services or fees regardless of insurance coverage. I further authorize the release of necessary information in order for Fort Payne Pediatrics to receive payment for services.

Signature of Guarantor: _____ Date: _____

THE PURPOSE OF OUR WELL WAITING ROOM

Please note that the Well Waiting Room is designated for well baby and well child check-ups **ONLY.** The primary purpose of this policy is to protect newborn babies and infants who are too young to have been fully vaccinated.

Please be seated in the SICK waiting area if:

- You, your child, or any friend or family member with you has or is showing symptoms of a communicable disease or illness, e.g., a cold, a rash, flu or strep, a fever, a cough, a runny nose, etc.
- You are here for **any** reason other than a routine well visit.
- Your child is over the age of two, and you have elected **not** to vaccinate your child.

****Please notify the front desk if your child is actively vomiting or having difficulty breathing, and a medical assistant or provider will immediately evaluate and isolate your child if necessary.****

SCENT-FREE ZONE

The chemicals used in scented products can make some people sick, especially those with fragrance sensitivities, asthma, allergies, and other medical conditions.

Please **DO NOT** wear perfume, scented lotions, cologne, aftershave, or other fragrances. Please use unscented personal care products on days you will be visiting our office.

Help us keep the air we share healthy and fragrance-free!

INACTIVE INSURANCE

As stated in our financial policy, if your insurance shows inactive or if we cannot verify your insurance, you will be asked to pay for the full visit up front or you will be asked to reschedule your appointment.

As a courtesy to you, if you can later show that your insurance was active at the time of the visit, we will reimburse you for the visit minus any copays, deductibles, or coinsurance **after** we receive payment from your insurance company.

PAYMENT OPTIONS

1. **Existing patients** who do not have delinquent guarantor accounts whose insurance cannot be verified may be seen for a sick visit as long as we have a valid credit card on file. If your insurance remains inactive after our initial billing cycle (2 weeks), we will charge the full amount of the visit to your credit card.
2. **Newborn patients** who do not have delinquent guarantor accounts whose insurance cannot be verified may be seen for up to two months. This two-month grace period allows you to complete all applications and send supporting documents to your insurance company after your child's birth. If your insurance remains inactive after the two-month grace period, see Payment Option 1 – Existing Patients.
3. **Medicaid patients** with an inactive policy are welcome to self-pay for services. Please be aware that Medicaid may not back-date any visits and will not reimburse you. Your retroactive coverage or policy renewal depends on how long ago your Medicaid eligibility expired. If it has been in the last month, you can either talk to your case worker or call the 1-800-362-1504 help line and ask them to update your record. If it's been longer than 6-8 weeks, you will need to reapply for Medicaid. The best way to do this is to apply online at www.insurealabama.org.

Please understand that the intent of these policies is to aid us in offering a high standard of care to our patients. They are not meant to be a burden. We also pledge to do our part to keep our schedule moving as efficiently as we possibly can!

Patient/Guardian Signature _____ Date _____