Hilliard Pediatrics Inc.

New Patient Information Form

Patient: _____
Last *First* *MI* *Prefers to be called*

Date of Birth: _____ SS#: _____ Gender: ☐Male ☐Female

Siblings Names (in this practice): _____

Legal Guardian #1 _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Phone: _____ OK to Text? ☐Yes ☐No

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Insurance Carrier: _____ Policy #: _____ Policy Holder: ☐Self ☐Other

Email Address: _____

Legal Guardian #2 _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Phone: _____ OK to Text? ☐Yes ☐No

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Insurance Carrier: _____ Policy #: _____ Policy Holder: ☐Self ☐Other

Email Address: _____

If parents are divorced or separated, please provide the following information:

Who has custody?_____ Primary parent to contact:_____

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 that child's medical records and/or treatment?_____

If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____

_____

_____

Emergency Contact: _____ Phone #:_____
(other than parent) Relationship to Patient: _____

Contact Preferences:

Primary contact for appointments: _____ Primary contact for insurance/billing: _____

How would you like to receive appointment reminders? *(circle one)* Phone Text Phone Number: _____
If phone call, preferred time of day: ☐ Morning ☐ Afternoon ☐ Evening

What email would you like to use for our patient portal? _____

I certify the information above is complete and correct.

X_____ Date:_____

Hilliard Pediatrics Inc.

FINANCIAL POLICY

Responsibility

When a patient is registered with Hilliard Pediatrics, we ask that the parent or guardian seeking care accept financial responsibility for payment. This can be updated at any time by completing a new copy of this form. Parents and guardians will be held responsible for understanding their insurance coverage terms and limitations as well as payment for amounts not covered by insurance.

Payments Due at Time of Service

1. Copays are expected to be paid at time of service when applicable. There will be a $5 administrative fee assessed each time copay is not paid at the time of service. If this amount is paid in full prior to a statement being generated, this fee will be waived.
2. If you do not have insurance coverage or you are insured by a company with which we are not contracted, payment in full is expected at the time of service unless other payment arrangements are made in advance.

Secondary Insurance

It is the responsibility of the parent/guardian to inform us if they have secondary insurance. Unless we are in possession of a court document stipulating otherwise, we follow the "birthday rule" to determine which is primary. Hilliard Pediatrics will bill secondary insurances that we are contracted with once. Any remaining balances will be parent/guardian responsibility.

Professional Services Rendered

If your child is seen for a scheduled preventative visit and another condition is treated at the same time, the provider will bill for each significant and separately identifiable service performed.

Laboratory Services

Most lab tests are sent and processed through Nationwide Children's Hospital (NCH). Certain labs can and will be performed in-house by our own staff. These tests will yield results during your visit; certain tests performed in-house are then sent to Nationwide Children's Hospital laboratory for confirmation. You may receive a bill for these tests from the outside laboratory in addition to our own in-house billing. Common labs that are sent out are strep cultures, urine cultures, and lead testing. If you do not want your child's test sent to NCH, please let your provider know at the time of service.

Cancelled/Missed Appointments

In the event that you are unable to make an appointment, please call the office at least 2 hours prior to the scheduled time to avoid a late cancellation fee. There will be a $25 fee added to your account for all unattended appointments or late cancellations.

Balances

All outstanding balances are due within 14 days upon receipt of your financial statement from Hilliard Pediatrics. Unpaid balances that are greater than 180 days old are subject to further collection activity and/or dismissal from the practice.

Payment Plans

Because we understand families may undergo financial hardship, we do offer payment plans. Your first payment will be due upon signing of the written agreement. Payment amounts will be based on amount owed. No payment plan will be given for amounts less than $100. If your payment plan is in default, the balance will be due in full. Failure to pay may result in further collection activity and dismissal from the practice.

Miscellaneous Fees

NSF-returned checks: $25 fee
Medical record copies: 1st electronic copy free, then $6.50 for additional electronic copies. Paper copies are charged per page at 50% of Ohio rate.
Forms: Standard forms are a $10 fee payable upon receipt of form. Forms completed at the time of a well visit are at no charge. FMLA forms are $25.00.
Saturday and After Hours: $20 fee. Fee applies to Saturday appointments and any visits scheduled outside of posted hours.

Divorce, Separation, and Custody Agreements

Hilliard Pediatrics will not be party to custodial, separation or financial disputes relating to individuals with regard to minor children to whom services are provided. The responsibility for payment is with the parent or legal guardian. In cases of child custody, the parent who presents their child for care and treatment is responsible for the payment of co-pays and any outstanding balances at the time of service. Any remaining balances are the responsibility of the financial guarantor of record. We ask that you do not request the office to collect payments from a parent who is not at, or may not be aware of the appointment. Our primary responsibility is to provide medical care for your child and our providers will act in their best interest. Upon request, Hilliard Pediatrics will provide a duplicate copy of your receipt so you can seek reimbursement where appropriate.

I agree to pay for any and all medical services my child receives from this practice that my insurance company refuses to pay for whatever reason. Hilliard Pediatrics will file a claim on my behalf; however, if my insurance company refuses to pay (e.g., termination of coverage, need for clarification of benefit information, and non-covered services such as developmental screenings, vision and hearing screenings, and urine dips), I will pay for upon written/verbal notice of their refusal. I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and considered fraudulent.

I authorize the release of any medical information necessary to process claims. I am aware that I can obtain a copy of this policy upon request. Policy is subject to change. Updates will be posted on our website at www.hilliardpeds.com.

Financial Guarantor Signature/Contact Information:

Financial Guarantor Name (*print*) _____ Date of Birth (*mm/dd/yyyy*) _____ Social Security Number ( ) -

Address / City / State / Zip _____ Primary Phone _____

Financial Guarantor Signature _____ Today's Date _____

Child(ren)'s Name(s): _____

Relationship to Patient(s): ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

Hilliard Pediatrics, Inc.

Consent for Release of Information

Patient Name: _____ DOB: _____

Test/Lab Results:

Please indicate where we are allowed to attempt to contact you with test/lab results:

Primary Contact: _____ ***Secondary Contact*** *(if applicable):*

☐ Home _____ ☐ Home _____

☐ Cell _____ ☐ Cell _____

☐ Work _____ ☐ Work _____

Many times when we call, we reach an answering machine or voicemail. Are we allowed to leave a detailed message with test results? ☐ Yes ☐ No, please leave a generic message

Note: Test results of a sensitive nature will ONLY be given directly to the parent/guardian, except where prohibited by law.

Billing/Financial Information:

There are occasionally situations in which we need to contact you regarding your insurance, payments, or past due statements. Please indicate your preferred number(s) to be reached:

Primary Contact: _____ ***Secondary Contact*** *(if applicable):*

1st # _____ 1st # _____

2nd # _____ 2nd # _____

Many times when we call, we reach an answering machine or voicemail. Are we allowed to leave a detailed message with patient names and specific balances? ☐ Yes ☐ No, please leave a generic message

Consent By Proxy – Anyone who is permitted to make and/or bring your child in for appointments and receive medical advice (other than parent/guardian)

I hereby authorize Hilliard Pediatrics, its representatives, physicians, and staff to share any and all relevant medical and financial information including outstanding balances to the following individual(s). The individuals listed below have authorization to bring my child into that office for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation and accept responsibility for payment. All copays are still due at the time of service, regardless of who brings the child in for an appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If there are any services that you do not consent to in your absence, please list:

_____

_____

In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If we cannot reach you, we will not refuse treatment if we feel the situation is emergent enough to warrant. This serves as consent for medical treatment we deem as medically necessary and appropriate.

I have read this form and certify that I understand its contents.

Printed Name: _____ _____ Date: _____

Mother, Father or Legal Guardian *Signature*

A VALID PHOTO ID MUST PRESENTED TO PROVE IDENTITY OF SIGNER

For office Use Only:

Guardian's Identity Verified By: _____ ID Type: _____ Date: _____

Hilliard Pediatrics, Inc.

Patient Consent for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

At Hilliard Pediatrics, Inc. we are committed to protecting the security and privacy of your child's person al information. Medical records are the property of Hilliard Pediatrics, Inc., kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for treatment of your child.

With my consent, Hilliard Pediatrics, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Hilliard Pediatrics, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have been given the opportunity to, review the Notice of Privacy Practices prior to signing this consent. Hilliard Pediatrics, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hilliard Pediatrics, Inc. Privacy Officer at 3855 Trueman Court Hilliard, Ohio 43026 or by going to www.hilliardpeds.com.

I understand that Hilliard Pediatrics, Inc., its attorney, and/or its agents, including collection agencies may call my home, cell phone, and place of employment for healthcare reasons, appointment reminders and to resolve billing issues. Hilliard Pediatrics, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Hilliard Pediatrics, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements and that appointment reminders may be sent via postcards.

It is our office policy NOT to fax Medical Information except to another medical provider.

I understand that Hilliard Pediatrics, Inc. may discuss protected health information with adults or other minors present during the visit. It is the responsibility of the patient and/or guardian to indicate otherwise during each visit.

Hilliard Pediatrics, Inc. participates in an organized healthcare arrangement through OhioHealth Group, Ltd. (OhioHealth Group). OhioHealth Group consists of an organized system of healthcare in which multiple covered entities participate. Through OhioHealth Group, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of OhioHealth Group.

I have the right to request that Hilliard Pediatrics, Inc. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hilliard Pediatrics, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hilliard Pediatrics, Inc. may decline to provide treatment to me.

I understand and agree to all of the above unless I strike through one of the statements.

_____	_____	_____
Signature of Patient or Legal Guardian	Printed Name	Date