PATIENT INFORMATION

Patient Name:_____ □ Male □ Female
Last First Middle
Patient's Social Security #:_____ Age:_____ Date of Birth (DOB):_____

Address:_____

City/State/Zip:_____ Cell Phone:_____

Race: □ American Indian □ Asian □ Native Hawaiian □ Black/African American □ White □ Hispanic □ Other □ Refuse to report

What made you choose Monroe Pediatrics, Inc.? _____

PARENT(S) OR GUARDIAN(S) GUARANTOR INFORMATION

PARENT/GUARDIAN NAME:_____ SSN:_____ DOB:_____
RELATIONSHIP TO PATIENT: □ MOTHER □ FATHER □ GRANDPARENT □ FOSTER PARENT □ OTHER_____

□ MALE □ FEMALE CELL PHONE:_____

Address:_____City/State/Zip:_____

EMPLOYER:_____ OCCUPATION:_____

WORK ADDRESS:_____ PHONE:_____

PARENT/GUARDIAN NAME:_____ SSN:_____ DOB:_____
RELATIONSHIP TO PATIENT: □ MOTHER □ FATHER □ GRANDPARENT □ FOSTER PARENT □ OTHER_____

□ MALE □ FEMALE CELL PHONE:_____

Address:_____City/State/Zip:_____

EMPLOYER:_____ OCCUPATION:_____

WORK ADDRESS:_____ PHONE:_____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND WE MAY CONTACT **AT A DIFFERENT ADDRESS:**

NAME: _____ PHONE: _____

ADDRESS: _____ RELATIONSHIP TO PT: _____

AUTHORIZATION TO LEAVE MESSAGES REGARDING PATIENT INFORMATION

I hereby authorize Monroe Pediatrics, Inc. to leave voice and/or text messages regarding testing results and scheduled appointments to the cell phone number(s) listed above (Standard SMS rates may apply).

PATIENT EMAIL ADDRESS: _____ _____
INITIAL HERE

OTHER

MOTHER'S MAIDEN NAME: _____

PREFERRED PHARMACY: _____ PHONE #: _____
HOW DID YOU HEAR ABOUT US?: □ INTERNET SEARCH □ PHONE BOOK □ INSURANCE COMPANY □ ADVERTISEMENT □ FRIEND/FAMILY
□ OTHER _____

PLEASE GIVE THE RECEPTIONIST **ALL** INSURANCE CARDS AT EVERY VISIT

MONROE PEDIATRICS, INC.
PARENTAL DESIGNATION FORM AUTHORIZING TREATMENT OF A MINOR

I _____, am the:
Print Parent/Guardian Name

□ Natural or Adoptive Parent

□ Guardian of

□ Person, who under court order is authorized to give consent for the minor:

Name: _____ DOB: _____
Print Name of Minor Minor's DOB

I authorize Monroe Pediatrics, Inc., to discuss and provide medical treatment of the above named minor with the following authorized adult(s) who are <u>over the age of 18</u> (ie: Grandparents, Siblings, Aunts/Uncles, Step-Parents, etc):

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

_____
Signature of Parent/Guardian

_____
Date Signed

FINANCIAL POLICY | ASSIGNEMENT OF BENEFITS | PAYMENT AGREEMENT MONROE PEDIATRICS, INC.

I understand, accept, and acknowledge the following terms:

- Payment for all services is my responsibility and is due and payable at the time services are rendered. Any checks returned unpaid by your financial institution will be subject to a fee of $35.00.
- Unless either I or my health coverage carrier has made prior arrangements in advance, full payment is due at the time of service. Any contract for Insurance coverage is made between my employer, the insurance company and myself. Monroe Pediatrics, Inc. has no influence over available benefits or the approval of claims.
- If my health insurance carrier has accepted Monroe Pediatrics, Inc. as a participating provider at the time of service, Monroe Pediatrics, Inc. will submit a claim to my insurance carrier.
- Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.
- If my health insurance carrier HAS NOT accepted Monroe Pediatrics, Inc. as a participating provider at the time of service, I am responsible for full payment at time of service. I understand charges for my child's care and treatment(s) are due at the time of service. (**No Exceptions!**)
- I will provide **all valid insurance information**, including primary and secondary insurance coverage. Failure to do so will result in termination of my relationship with Monroe Pediatrics, Inc. and I will be immediately dismissed from the practice and deliver prompt payment for all involved dates of service.
- Any credit on my account will be a credit only, and not refunded by Monroe Pediatrics, Inc. unless I request one in writing.
- If I wish to use my insurance benefits to cover the cost of any ordered tests, procedures or visits to third party providers it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers and specialists. Payment for such services is my responsibility under the terms provided by said individuals.
- Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to my insurance carrier.
- **Non-Covered Services**: All health plans are not the same and do not cover the same services. In the event my health plan determines a service to be "not covered" I will be responsible for the complete charges. I understand payment is due at the end of the office visit or upon receipt of a statement from Monroe Pediatrics, Inc. (if determined after billing is complete).
- **Well-Child Checks**: Periodic preventative health checks may or may not be covered under my health insurance policy, therefore, I will review my individual plan(s) for coverage information. Should one not be covered and I desire for my child to have one, I will pay for the visit at the time of the visit.
- **Personal Injury Cases**: I understand Monroe Pediatrics, Inc. does not bill for auto accidents or other liability or lawsuit related cases. I am responsible for payment at the time of service. I will submit my own claims. Monroe Pediatrics, Inc. does not accept liens.
- **Minor Patients**: For all services rendered to minor patients, I understand the adult accompanying the patient and the parent or guardian with custody is responsible for co-pays, deductibles, co-insurance, and outstanding account balances at the time of service.
- **Missed Appointments**: In fairness to other patients and the physician, I will provide at least a 24 hour notice to cancel well-child checks. Otherwise, I will pay a fee as follows for missed appointments: $20.00 for well child visits. Three missed appointments within a year will cause dismissal from Monroe Pediatrics, Inc.
- I agree to pay for all charges for services rendered and/or materials furnished for this and any future visit.
- I hereby authorize **Monroe Pediatrics, Inc**. to release any medical information concerning my illness and treatment deemed necessary to process this claim and any future claims to all insurers having responsibility for charges incurred. Additionally, I hereby assign all insurance benefits due me be paid to **Monroe Pediatrics, Inc**. For any amounts not paid by me, I direct all insurers pay directly to **Monroe Pediatrics, Inc**. all such benefits. I understand that I am responsible for any amounts not covered by insurance. A copy of this signature is as valid as the original.
- An account will be considered outstanding if not paid within thirty (30) days of the invoice/bill and may bear interest of 18% per annum (1.5% monthly). It is also understood and agreed to by the undersigned patient (or parent(s)/guardian of minor child) that any account, which becomes more than ninety (90) days delinquent may be turned over to our Attorney for initiating litigation to collect the outstanding invoice. In such event, the undersigned patient (or parent(s)/guardian of the minor child) understands and agrees he/she will be responsible for the original invoice amount, **plus** the collections company fee of thirty percent (30%) of the original invoice amount, interest as may be applied, an Attorney's fee of forty percent (40%) of the outstanding balance of all invoices turned over, and all court costs incurred as a result of litigation.

COLLECTION POLICY & AGREEMENT

When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein including but not limited to reasonable attorney's fees may be sent to outside collection firms for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs. Such fee represents administration, accounting, bookkeeping, account maintenance, legal and management fees associated with delinquent accounts. In consideration of the acceptance of the patient named on this form by Provider and for services rendered or to be rendered to such patient, the undersigned promises to pay for and guarantees payment of all amounts due and any and all charges including collection costs described herein. If payments due hereunder is not made as agreed, Monroe Pediatrics, Inc., may without notice or demand, declare the entire unpaid balance of the account including collection costs agree to herein to be immediately due and payable. If court action is necessary to enforce payment hereunder, the venue for any such court action shall be in Walton County, Georgia unless Monroe Pediatrics, Inc. elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Agreement shall be as valid as the original.

I have read and understand the financial policy of the practice and I agree to be bound by its terms for payment of all professional fees. By signing this statement, you and your designated parties have agreed that the insurance information you have provide to MONROE PEDIATRICS, Inc. is the only health insurance coverage for the patient. I understand and agree that such terms may be amended by the practice. The patient/parent is ultimately responsible for all professional fees.

Signature of Parent/Guardian: _____ Date: _____

Print Name of Parent or Guardian: _____

Please Print FULL Name of the Patient: _____ Date of Birth: _____