Blackmon pediatrics

NEWBORN INFORMATION PACKET

PATIENT NAME: ______________________ **DATE OF BIRTH:** ____/____/______

Please complete the following forms and read and sign the "Parent's Responsibility for Health Insurance" below:

- ❍ Pediatric Demographic Form (Page 2)
- ❍ Financial Policy Acknowledgment Form (Page 3)
- ❍ Consent For Healthcare Messages Form (Page 4)
- ❍ Consent to Accompany Minor Child for Medical Treatment Form (Page 5)

PARENT'S RESPONSIBILITY FOR HEALTH INSURANCE

Please contact your insurance company **TODAY** to get your newborn added to your health insurance plan.

Health Insurance companies typically allow **30 DAYS** to contact them and provide your newborn's social security number and birth certificate. If this is not completed within that 30 DAY time frame, the insurance carrier may deny all claims submitted on behalf of your newborn for medical care, leaving you responsible for all medical expenses until the child has been successfully added to the insurance coverage. Some health plans may not allow the child to be added until the next "open enrollment period," which could be up to one year.

"As the parent of the patient listed above, I have read and I understand my responsibility to notify the health insurance carrier of the birth of my child and to provide them with the appropriate documentation and paperwork as requested by the health insurance carrier. I accept full responsibility of any medial expenses that are denied due to any failure to obtain health insurance coverage for my child in accordance with the insurance carrier requirements." time frame."

______________________ ______________________

PARENT | LEGAL GUARDIAN SIGNATURE **DATE**

______________________ ______________________

PARENT | LEGAL GUARDIAN PRINTED NAME **RELATIONSHIP TO PATIENT**

BLACKMON PEDIATRIC USE ONLY

RECEIVED BY: **DATE:** **REVIEWED** ❍ **ENTERED IN eCW** ❍

STATEMENT OF CONFIDENTIALITY: *The information contained in the pages of this information packet is privileged and confidential and intended only for the use of Blackmon Pediatrics. If the reader of this information is NOT the intended recepient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited under government legislation (HIPAA). If you have received this information in error, please immediately notify us by telephone and return the original documents to us at the address listed below via US Postal Service. Thank you.*

PATIENT INFORMATION

	PATIENT NAME(S)	DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER
1	________	___/___/___	○ MALE ○ FEMALE	___•___•___
2	________	___/___/___	○ MALE ○ FEMALE	___•___•___
3	________	___/___/___	○ MALE ○ FEMALE	___•___•___
4	________	___/___/___	○ MALE ○ FEMALE	___•___•___
5	________	___/___/___	○ MALE ○ FEMALE	___•___•___

PATIENT PORTAL INFORMATION

EMAIL ADDRESS ________________

PREFERRED PHONE # FOR REMINDERS (____) ______-______

RESPONSIBLE PARTY INFORMATION

GUARDIAN 1

NAME: ________________

DATE OF BIRTH: ___/___/___

SOCIAL SECURITY #: ___•___•___

ADDRESS: ________________

____

PRIMARY PHONE #: (____) ______-______

EMPLOYER NAME: ________________

WORK PHONE #: (____) ______-______

GUARDIAN 2

NAME: ________________

DATE OF BIRTH:

SOCIAL SECURITY #: ___•___•___

ADDRESS: ________________

____

PRIMARY PHONE #: (____) ______-______

EMPLOYER NAME: ________________

WORK PHONE #: (____) ______-______

EMERGENCY CONTACTS

NAME: ________________

RELATION: ________________

PHONE #: (____) ______-______

NAME: ________________

RELATION: ________________

PHONE #: (____) ______-______

INSURANCE INFORMATION

PRIMARY INSURANCE ☐ **NO INSURANCE COVERAGE**

INSURANCE COMPANY: ________________

INSURANCE ID #: ________________

INSURANCE GROUP #: ________________

CARDHOLDER'S NAME: ________________

DATE OF BIRTH: ___/___/___

RELATION TO PATIENT: ________________

SECONDARY INSURANCE ☐ **NO SECONDARY POLICY**

INSURANCE COMPANY: ________________

INSURANCE ID #: ________________

INSURANCE GROUP #: ________________

CARDHOLDER'S NAME: ________________

DATE OF BIRTH: ___/___/___

RELATION TO PATIENT: ________________

FINANCIAL ACKNOWLEDGEMENT

I, the undersigned individual, authorize payment of medical benefits to Blackmon Pediatrics for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance contract and any unpaid claims after 30 days. I also authorize Blackmon Pediatrics to release to my insurance company or their agent, information concerning healthcare, advice, treatment, documentation, and/or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

PARENT | GUARDIAN SIGNATURE: ________________ DATE: ___/___/___

PARENT | GUARDIAN NAME (PRINTED): ________________

INSURANCE

Please bring your insurance card(s) with you to every appointment. It is the patient's parent/guardian to notify the front desk staff of any changes in insurance coverage and/or when the claim should be billed to your auto insurance carrier or workers comp. We accept most insurance plans and will gladly file your claims for you. Please check with your insurance carrier to determine if our physicians/providers participate with your plan. If we do NOT participate with your insurance plan, you will be responsible for the balance and filing of the claim.

Blackmon Pediatrics does NOT currently accept the following insurance plans:
AMERICHOICE, AMERIGROUP, UNITED HEALTHCARE COMMUNITY PLAN or INSURANCES via HEALTHCARE.GOV
(This is NOT a complete list, so please verify that our providers are participating with your insurance plan and network.)

FINANCIAL POLICIES

- **CO-PAYMENTS** are due on the date services are rendered.
- **SELF-PAY PATIENTS** (those not covered by an insurance plan or those opting to not bill insurance for specific charges) will be offered a pricing discount for most charges. Payment is expected on the date services are rendered unless other arrangements are made, documented, and sign by the parent/guardian and a Blackmon Pediatrics assigned agent.
- **FLEXIBLE PAYMENT PLANS** - Payment is expected within 30 days of the statement date, however, flexible monthly payment arrangements can be made for large balances on an individual case by case basis.
- **GUARANTOR INFORMATION** - any change in the guarantors address, phone number, or email address should be provided to our practice as soon as the information is available and is the responsibility of the guarantor and/or parent/guardian.
- **REFUNDS** - if an overpayment is made on your account or your account accrues a balance, the refund or statement will be issued to the address of the guarantor on file. A refund will not be issued if the guarantor/patient has any unpaid balance on the account. Refunds will be issued by request and should be processed within 30 days. Refunds not requested, will remain on the account to cover future charges.
- **RETURNED CHECKS** - any account with a returned check will be charged a $25.00 service charge.
- **FORMS OF PAYMENT ACCEPTED** - we accept: Cash, Personal Checks, Mastercard, Discover, and Visa for your convenience.

FINANCIAL RESPONSIBILITY - belongs to the parent/guardian/guarantor that brings the child for medical care, regardless of Divorce Decrees, Court Orders, or other legal directives. Blackmon Pediatrics is equipped to provide excellent medical care to your child(ren), however, we are not equipped to deal with the myriad of legal processes that may occur. Therefore, it is our policy to not get involved with those situations, and to simply focus on the health and well-being of your child.

NO SHOW POLICY

Our office has automated methods of reminding our parents/guardian/gaurantors of upcoming appointments. It is imperative that the contact information listed in the "patient portal information" on the demographic sheet is kept up to date. It is the parent/guardian/ guarantors responsibility to maintain current Email address and Phone number for reminders. Failure to keep scheduled office appointments prevents other patients from receiving access to our care while also depriving those in your care from the medical assessment and care that they need. We are sensitive to the fact that unforeseen circumstances may occur that prevent you from keeping your scheduled appointment. Therefore, please notify our office 24 hours prior to your appointment to reschedule whenever possible. Any appointments canceled on the day of the appointment or any appointments that the patient fails to arrive for, will be billed a $25 charge. Any patient that accumulates three (3)(or more "no shows" in a six (6) month period, will be considered for dismissal from the practice. In addition, we are obligated under many of our managed care contracts to report patient's who repeatedly fail to pay co-pays and deductibles as well as those who repeatedly fail to show for a scheduled appointment. If you are reported, there is a possibility your child(ren) could lose their health care benefits.

TERMINATION

Parent/Guardian termination of the patient-provider relationship with Blackmon Pediatrics, for any reason, will result in the immediate conclusion of medical care for the patient(s). Blackmon Pediatrics will be free from any responsibility to provide care, standard or emergent. A copy of your child's medical record is available for release upon the completion of the proper release document(s). Please note, we will fax one complimentary copy of the medical record to your new provider at no cost; however, for a hard copy there is a $20 fee for the first 5 pages, and an additional 0.50 cent fee for each page thereafter. Note: Medical records can be retrieved free of charge from the Patient Portal.

ONE TIME ACCEPTANCE & AUTHORIZATION OF CONTENT

The signature below indicates that I have read, understand, accept, and will comply with the content of this policy. I further authorize Blackmon Pediatrics to provide my child(ren) with reasonable and proper medical care as outlined by the standards of today. This further authorizes Blackmon Pediatrics to provide care to my child(ren) in the event they are brought by someone other than me, on my behalf as designated on the "Consent to Medical Treatment and to Accompany Minor Child" form.

PARENT | GUARDIAN: ______________________________ DATE: ______/______/________
SIGNATURE

PARENT | GUARDIAN: ______________________________ RELATION TO PATIENT: ______________

Blackmon pediatrics

CONSENT FOR HEALTHCARE MESSAGES

PATIENT NAME: ______________________________ DATE OF BIRTH: _____/_____/_______

TEXT | VOICE MESSAGES FOR GENERAL HEALTHCARE INFORMATION

"I give permission to the physicians and their staff at Blackmon Pediatrics to":
(Initial all approved options)

☐ Leave TEXT MESSAGES at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my/my child's healthcare when I am not available.

☐ Leave VOICE MESSAGES at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my/my child's healthcare when I am not available.

VOICE MESSAGES FOR PERSONAL HEALTH INFORMATION & RESULTS

☐ Leave VOICE MESSAGES regarding my/my child's health information including test results and diagnostic information payments of balance, care plans, referrals, when I am not available.

CELL NUMBER: (_____)_____-_________ PHONE NUMBER: (_____)_____-_________

CELL NUMBER: (_____)_____-_________ PHONE NUMBER: (_____)_____-_________

SHARING OF HEALTH INFORMATION & RESULTS

☐ Share my/my child's health information including results, diagnosis, and appointment information with the following individual(s): **NOTE: Individuals listed below will also be permitted to pick up paperwork on your behalf.**

NAME	RELATION	PHONE NUMBER
		(_____)_____-_________
		(_____)_____-_________
		(_____)_____-_________
		(_____)_____-_________
		(_____)_____-_________

PATIENT: ______________________________ DATE: _____/_____/_______
SIGNATURE | IF 18 YEARS OLD & OVER

PARENT | GUARDIAN: ______________________________ DATE: _____/_____/_______
SIGNATURE

PARENT | GUARDIAN: ______________________________ RELATION TO PATIENT: ______________
PRINTED NAME

CONSENT TO ACCOMPANY MINOR CHILD FOR MEDICAL CARE

PATIENT NAME: ________________________ **DATE OF BIRTH:** ____/____/______

Blackmon Pediatrics believes it is in the best interest of a minor child to be brought in for treatment by a parent and/or legal guardian. However, we are aware that there are circumstances that arise that may require a caregiver (other than a parent or legal guardian) to bring the minor child to the office for medical treatment. In those instances, we require a parent and/or legal guardian to provide their written consent for us to provide medical treatment to the the minor child when accompanied by someone other than a parent or legal guardian.

Please list below any caregiver(s) that you authorize to accompany your minor child to the office of Blackmon Pediatrics for physical examination and/or medical treatment:

NAME	RELATION	PHONE NUMBER
________________________	____________	(____) _____-_______
________________________	____________	(____) _____-_______
________________________	____________	(____) _____-_______
________________________	____________	(____) _____-_______
________________________	____________	(____) _____-_______

I certify that I am the parent and/or legal guardian of the minor child listed on this document and I give authority to the caregiver(s) listed above to accompany my minor child to your office for medical treatment in my absence. I further acknowledge the following:

- This consent of treatment includes but is not limited to: immunizations, prescription and over the counter medication administration, diagnostic and laboratory testing, blood draws, and any procedures that a provider of Blackmon Pediatrics deems to be medically necessary and appropriate for my minor child.
- This consent acknowledges that the caregiver(s) may have access to the minor child's written medical health care record as well as verbal discussions regarding the minor child's historical and/or current medical diagnosis and plan of care.
- As the parent and/or legal guardian, I will make every effort to be available by phone to discuss medical treatment options and/or concerns regarding the medical condition of my minor child.

PRIMARY CONTACT NUMBER: (____) _____-_______ **SECONDARY CONTACT NUMBER:** (____) _____-_______

- As the parent and/or legal guardian, I will be financially responsible for all expenses that occur due the treatment of my child, in the event that the guarantor (if not the signatory of this document) of my minor child fails to meet the financial obligations regarding any visit where a caregiver(s) accompanies my minor child in my absence.
- As the parent and/or legal guardian, I am responsible to update this consent if/when any information contained within this document changes. Futhermore, this consent will remain in effect until it is revoked in writing and/or replaced by an updated version of the form which will be determined by the most recent date listed beside the signature below.

PARENT | GUARDIAN: ________________________ **DATE:** ____/____/______
SIGNATURE

PARENT | GUARDIAN: ________________________ **RELATION TO PATIENT:** ____________
PRINTED NAME