Eastern Shore Children's Clinic - Patient Information

Child's Name _____ Today's Date _____
Child's Nickname _____ Child's Sex (circle): Male or Female
Child's Birth Date _____ Social Security Number _____
Race (circle): American Indian/Alaskan | Asian | Black/African American | White | Other_____
Ethnicity (circle): Hispanic/Latino or Non-Hispanic/Non-Latino
Language (circle): English Spanish French Other_____
Parent's Marital Status (circle): Married Divorced Single Widowed
Mother's Name _____ Mother's Social Security #_____
Mother's Home Phone _____ Mother's Cell Phone_____
Mother's Mailing Address _____ City_____ State____ Zip_____
Mother's Employer _____ Mother's Work Phone_____
Mother's Drivers License Number_____ Mother's Date of Birth _____
Father's Name _____ Father's Social Security # _____
Father's Home Phone _____ Father's Cell Phone _____
Father's Mailing Address _____ City_____ State____ Zip_____
Father's Employer _____ Father's Work Phone _____
Father's Drivers License Number_____ Father's Date of Birth_____
Child Lives With (circle one): Both Parents Mother Father Other _____
Parent's Home Email Address _____
Emergency Contact _____ Relationship_____ Phone # _____

Insurance Information

Please provide Insurance card(s) and Driver's License so we can copy for our records

Insurance Company_____ Subscriber's Name_____
Subscriber's Policy Number _____ Group #_____
Co-pay Amount_____ Subscriber DOB_____ Secondary Insurance? Yes or No

Pharmacy Information

Preferred Pharmacy_____ Pharmacy phone number _____

Family Information

Sisters (Full Name)_____	Date of Birth_	Brothers (Full Name)_____	Date of Birth_
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial Responsibility

I understand that it is my responsibility to provide current and correct insurance information on the date of service. I agree to accept financial responsibility for any procedure that is either not covered by my insurance company or not paid by my insurance company within a timely manner. Appointments not cancelled at least 4 hours prior to your appointment time will be considered "no-shows". We reserve the right to bill you $25.00 for each no-show. This fee will be your responsibility and will not be billed to your insurance company.

Signed _____ Date _____

Relationship to the Child_____

What was the reason you chose our practice?_____

Eastern Shore Children's Clinic
Past, Family and Social History

Child's Name_____ Today's Date _____

Birth Information

Hospital _____ City _____ Obstetrician _____
Birth Weight _____ Birth Length _____ Type of Feeding _____
Gestational Age _____ Jaundice requiring treatment _____
Complications of Pregnancy, Labor or Delivery (describe) _____
_____

Past History

Medications _____
_____
Allergies (list reaction) _____
_____
Surgeries _____
_____
Hospitalizations(date and reason) _____
_____

Illnesses(detail positives)

ADD/ADHD _____ Heart Disease _____
Anemia _____ Thyroid Problems _____
Asthma _____ School Problems _____
Bleeding Problems _____ Sinus Problems _____
Depression _____ Seizures _____
Diabetes _____ Other _____
Ear Infections _____ _____
Eczema _____ _____

Family History

Note family members having the following diseases with these codes: N-none, F-father, M-mother, S-sibling, GP-grandparent, O-other.

_____ ADD
_____ Alcohol/Drug Abuse
_____ Anemia
_____ Anxiety
_____ Asthma
_____ Bleeding/Clotting Disorder
_____ Birth Defect (explain) _____
_____ Cancer
_____ Cholesterol Problem
_____ Depression
_____ Developmental Delay
_____ Diabetes
_____ Foster Care
_____ Heart Disease
_____ Tuberculosis
_____ Stroke

Social History

Who does child live with? _____
Does the child attend daycare? ___yes ___no
If child is age 13 or older, does child smoke? ___yes ___no
Are their smokers in the household? ___yes ___no
Do you have pets? ___yes ___no; If yes, what type_____

Eastern Shore Children's Clinic - PHI **Patient #(s): _____**

With my consent, Eastern Shore Children's Clinic may use and disclose protected health information (PHI) about me to carryout treatment, payment and health operations (TPO). Please refer to Eastern Shore Children's Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eastern Shore Children's Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to Eastern Shore Children's Clinic Privacy Officer at 150 South Ingleside St., #7 Medical Park, Fairhope, AL 36532.

With my consent, Eastern Shore Children's Clinic and/or their forwarding collection agency, may call my home or other designated location(s) and leave a message or voice mail, or in person in reference to any items that assists the practice in carrying out TPO, such as appointment reminders, insurance items, delinquent balances and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Eastern Shore Children's Clinic may mail to my home or other designated location any items that assists the practice in carrying out TPO, such as appointment cards and patient statements. I have the right to request that Eastern Shore Children's Clinic restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement. By signing this form, I am consenting to Eastern Shore Children's Clinic's use and disclosure of my PHI to carry out TPO.

With my consent financial and medical information, as well as being allowed to accompany my child to the office for a physician visit will only be given to the persons below identifying themselves as one of the following:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

*******Availability of Records to Both Parents (AL ST § 30-3-154)

AL ST § 30-3-154

Unless otherwise prohibited by court order or statute, all records and information pertaining to the child, including, but not limited to medical, physiological, dental, scholastic, athletic, extracurricular, and law enforcement, shall be equally available to both parents in all types of custody arrangements.

Please be aware that ALL information will be available to BOTH parents regardless of custody arrangement unless legal documentation is presented to Eastern Shore Children's Clinic revoking all parental rights.

In signing this agreement I realize that Alabama state law considers my child an adult at age fourteen (14) regarding medical decisions. When my child reaches age fourteen (14) we must have your child sign a document giving permission for access of records.

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, Eastern Shore Children's Clinic may decline to provide treatment to me.

I have been made aware of the Notice of Privacy Practices for Eastern Shore Children's Clinic. I understand that I may receive a complete copy of the Notice of Privacy Practices upon request.

I have been made aware that Eastern Shore Children's Clinic provides care for patients under the age of 19. I understand that once a patient reaches the age of 19 it is the responsibility of the patient to find another healthcare provider.

_____	_____	_____
Signature of Patient/Legal Guardian	*Date*	*Printed name of Patient/Legal Guardian*
_____	_____	
Patient's Name	*Date of Birth*	
_____	_____	
Patient's Name	*Date of Birth*	
_____	_____	
Patient's Name	*Date of Birth*	(Revised 01-29-16)

EASTERN SHORE CHILDREN'S CLINIC
FINANCIAL POLICY

We here at Eastern Shore Children's Clinic (ESCC) are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is expected at the time services are rendered unless other arrangements have been made in advance. I understand that I am responsible for any unpaid balance, copayments, coinsurance, deductibles and non-covered charges and unconditionally guarantee payment in full to ESCC for all treatment and services rendered to the patient. Failure to pay copayments on the service date may result in an additional fee. ESCC accepts cash, checks, debit cards, VISA, MasterCard, American Express, and Discover. There is a service charge for returned checks and we reserve the right to make your account a "cash only" account for future visits.

Patients with an outstanding balance are asked to pay their balance in full at time of receipt of their statement. We do realize that patients may have financial difficulty. Therefore, we advise you to call our Billing Coordinator, at 928-0624, extension 233, Tuesday through Friday between 9:00 a.m. and 4:00 p.m. to discuss your account.

INSURANCE

We bill participating insurance companies as a courtesy to you (*this includes Commercial Insurance, Group Insurance, and Medicaid*). You are expected to be familiar with what your copayment amounts are, what your yearly deductible is, what your insurance does or does not cover, etc. There are too many plans within plans for us to be able to know them all. Your employer provides numbers for you to call to ask these questions. When we check for eligibility at the time of your appointment and your insurance shows ineligible, you are responsible for the entire bill at the time of service.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Cancellations should be made no later than 4 hours prior to your scheduled appointment time. Appointments not cancelled at least 4 hours prior will be considered "no-shows". Arriving more than 15 minutes late for an appointment will also be considered a no-show. No-show appointments represent a cost to us, to you, and to other patients that could have been seen at the time set aside for you. We reserve the right to bill you $25.00 for each no-show. This fee will be your responsibility and will not be billed to your insurance company. After three (3) no-shows we reserve the right to dismiss your family from our practice.

I have read and understand the ESCC Financial Policy. I agree to assign insurance benefits to ESCC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the 33% fee charged by the collection agency on the total balance owed.

Signature of Insured or Authorized Representative: _____

Printed Name of Insured or Authorized Representative: _____

Date: _____