Children's Health Service's, P.A. · 1826 West Arlington Blvd · Greenvill

Patient's Name: ____

Patient's Name: ____

Patient's Name: ____

Please list Legal Guardians below:

NAME	RELATIONSHIP TO PATIENT	CONTACT NUMBER	CELL PHONE PROVIDER	EMAIL

The following person(s) have permission to authorize medical care for my child and sign any necessary waivers on my behalf.

NAME	RELATIONSHIP TO PATIENT	CONTACT NUMBER

Please check YES or NO to the following:

For patients 16 years old and older ONLY- The patient has permission to be treated unaccompanied by an adult.

- o YES
- o NO

Children's Health Services, P.A. may leave voicemails on the numbers provided.

- o YES
- o NO

Children's Health Services, P.A. may communicate through the email provided.

- o YES
- o NO

Signature: ____ **Date:** ____________________

If any updates need to be made to the patient's account, this paperwork must be completed. Otherwise, it is to be completed annually.

PLEASE COMPLETE REVERSE SIDE

Updated 11-17-16

HIPAA Notification

Our Practice has implemented the Health Information Portability and Accountability Act to protect in th information. In the Parent/Guardians absence we will request that all persons with the patient have : * 787065w16083 Admin compare to the child's Consent for Treatment and Patient Health form that the Parent/Guardian completes on an annual term. If the person with the patient is not listed in the patient's profile, we will be contacting you to confirm. Anyone other than the parent picking up prescriptions, forms or any other information on your child will need to present a valid photo ID also.

Current Information

You are required to notify Children's Health Services of any change of the patient's information, such as insurance, benefits, patient's name, custody orders, employer, address and contact numbers. You will have to present a current insurance card at each appointment.

Payment at Time Service

If your insurance plan requires you to pay a co-payment, it will be collected during check-in. Patients that fail to bring their co-pay will be required to reschedule their non-urgent appointment. If you are a self-pay patient or your insurance information cannot be verified prior to the appointment, you will be required to pay in full at the time of service. If your insurance requires payment of an annual deductible or co-insurance, payment will be calculated at the time of check out and due. We accept payments in the form of Cash, Check, Master Card, Visa, and Care Credit. If you have any questions, please see one of our account representatives for more information.

Claims Filing

As a courtesy to our patients, we will file claims with your insurance company and also coordinate benefits with secondary payers. You will be responsible for timely payment of any patient balances as directed by your insurance. You will also be responsible in the event that the claim is disputed or unpaid.

Patient Billing and Collections

Patients that receive a statement from Children's Health Services are expected to remit a full payment upon receipt, unless previous payment arrangements were made with our billing representatives. If your account balance is not resolved within 60 days, your balance will be referred to an outside collection agency for non-payment and a fee will be added to your account. Patients with accounts in collections must make payment arrangements prior to scheduling further appointments with our practice. **If you receive a billing statement and do not understand it, please contact our office for assistance.**

After-Hours Office Visits

Patients scheduled outside of our normal business hours will be charged an after-hours charge. This charge may or may not be covered under your insurance plan. This applies to services received at Children's Health Services, not the ECU After-Hours clinic.

No-Shows

For patients that fail to come to their appointment and do not notify our office 24 hours in advance of the need to cancel, a **$65.00 NO-SHOW CHARGE** will be added to your account. This charge will be the patient's responsibility. If a patient has two or more no shows, you are automatically eligible for discharge. Please notify our office if you cannot keep your appointment, so that other patients in need of medical care can be seen.

Late Policy

You are responsible for arriving to your scheduled appointment on time. Children's Health Services reserves the right to cancel patients that arrive fifteen minutes late for their appointment. This will also count as a NO-SHOW, please see the above policy for details.

Please acknowledge the above-mentioned policies by signing below:

Signature: ______________________________ Date: ______________