PATIENT INFORMATION FORM

Please **PRINT LEGIBLY** and **COMPLETE ALL information** on this form.

Last	**First**	**D.O.B.**	**Resides With**
Last	**First**	**D.O.B.**	**Resides With**
Last	**First**	**D.O.B.**	**Resides With**
Last	**First**	**D.O.B.**	**Resides With**
Last	**First**	**D.O.B.**	**Resides With**

MOTHER'S NAME: ________________ ______________ _____________ _______________ ______________________
Last First Middle D.O.B. Last Four digits of S.S.N.
Address: ____ Phone No: ______________________________
City, State, Zip:____
Employer: ____ Occupation:__________________________________
Cell Phone No: _____________________________________Home Phone No:____________________________________

FATHER'S NAME: ________________ ______________ _____________ _______________ ______________________
Last First Middle D.O.B. Last Four digits of S.S.N.
Address: ____ Phone No: ______________________________
City, State, Zip:____
Employer: ____ Occupation:__________________________________
Cell Phone No: _____________________________________Home Phone No:____________________________________

PLEASE LIST ALL INDIVIDUALS THAT HAVE YOUR PERMISSION TO BE INVOLVED WITH YOUR CHILD – CHILDREN HEALTH CARE & MIGHT ACCOMPANY THEM IN TO OUR OFFICE.

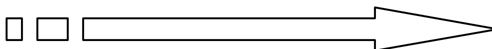
PLEASE NOTE - if an individual's name does not appear on this list and presents your child to this office for treatment they will be asked to reschedule the appointment at which time they can provide us with your authorization for treatment.

Names & Relationship to the child:
1.____ 6.____
2.____ 7.____
3.____ 8. ____
4.____ 9. ____
5.____ 10.____

Patient Acknowledgement of Children's Clinic of Wyomissing for the Protection of Identity Theft Red Flag Law & Patient Consent for Use and Disclosure of Protected Health Information & Financial Policy.

Children's Clinic of Wyomissing has established an Identity Theft Prevention and Detection Program to detect and prevent or mitigate the theft of patients' financial and other identifying information. Medical identify theft is a serious problem. It can result in adverse financial consequences to the practice and our patients. In addition, if it results in incorrect information being included in a patient's medical record, it can lead to inappropriate medical care.

ALL parties are to present our office with picture ID (driver's license, green card, passport, employee ID card, or student ID card) as well as their insurance card which will be scanned in to our system for identification purposes and to assist with possible red flags and Identity theft.



Furthermore, in signing this form, you consent to the use and disclosure of your protected health information by Children's Clinic of Wyomissing, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our *Notice of Privacy Practices* prior to signing this consent. We encourage you to review our *Notice of Privacy Practice*s carefully. It provides more detail on how we may use and disclose your information. The *Notice of Privacy Practices* may change. A current copy may be requested when you are being seen as a patient, by contacting our Privacy Officer at 610-376-8691.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment / service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the *Notice of Privacy Practices* for further information.

***In order for compliance with Meaningful Use Mandate Federal Government requires us to ask the following questions.**

Your Primary language________________________________
Ethnicity: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Decline to answer**

Race: ☐ **Asian** ☐ **Black** ☐ **Hawaiian Native or Pacific Islander** ☐ **White** ☐ **Decline to answer**

Financial Policy

It is our hope that our patients understand our credit and collections policies are a necessary part of assuring the financial resources required to maintain vital health care service for our patients and the community. Regardless of your insurance coverage, it must be understood that this is an agreement between you and the insurance company to pay certain amounts for medical care. Your Doctor's bill is an agreement between you and your doctor. You are responsible for making sure your bill is paid promptly and in full. Patients must remember that professional services are rendered and are never contingent upon the outcome of pending lawsuit, insurance disputes, or reimbursement from insurance companies.

All patients must present current insurance card at each visit. Co payments and outstanding balances for all medical services are due and payable in *full* at time of service. In the event that you shall come unprepared to pay for the service you will be asked to reschedule the appointment. You may pay by cash, check, Visa, MasterCard, Discover, ATM or American Express.

We do not get involved with domestic disputes and custody cases. Our policy is to obtain payment at the time of service from the parent/guardian bringing the child to the office. The person who the patient resides with is responsible for any balances due upon receipt of a statement. A $22.50 charge will be added to any account that had a check returned to us and $30 for checks with a stopped payment. All our appointments are scheduled appointments and are subjected to a $30.00 No-Show charge if not canceled in an appropriate time.

Our financial statements are on a 15-day cycle. Accounts 60 days past due are referred to a collection agency, except where hardship or previous credit arrangements have been made with the billing department. In those instances the agreed payment is due on the same day of each and every month. If there should be a delinquent payment without notice to the billing department the account will be turned over to the collection agency for further action. Accounts that are referred to Collection Agency will be charged $50.00 administration fee that is applied to the total balance. Patients referred for collections will not be able to schedule well visits till the balance on the account is paid in full.
If the account remains unpaid Patient will be asked to transfer their care to another office.

If unusual circumstances if it would make it impossible for you to meet our credit terms, we invite you to call and personally discuss the matter with our Clinical Director. This will avoid misunderstandings and enable you to keep your account in good standing.

Charges for medical care rendered by this office will be billed through this office and should not be confused with charges for care received in the hospital. Should you have any further questions, please contact our Billing Department at 610-376-5341.

I have read and agree to the terms of these Policies.

Signature of responsible party: ____ Date: ______________________________

For Practice use only
Failure to obtain consent Check the appropriate reason:
☐ Indirect Treatment Relationship ☐ Emergency treatment
☐ Substantial Communication Barrier ☐ Refusal to Sign ☐ Other

___________________________________ ____________________
Practice Signature Date

Policy reviewed and adopted July 01, 2012