

Redmont Pediatric Associates, P.C. Financial Responsibility/HIPAA/Consent

Patient's Name (Print Please): _____ DOB: _____

I hereby assign to Redmont Pediatric Associates, P.C. all payments for medical services rendered. I acknowledge full financial responsibility for all services provided, both those covered by my insurance contract and those non-covered services that may be deemed necessary for appropriate medical care. I **ACCEPT FULL** responsibility for knowing what my insurance benefits are and will advise the staff of Redmont Pediatric Associates, P.C. accordingly should my benefits change. I understand that charges incurred are **DUE AT THE TIME OF SERVICE**.

I also understand that fees may be incurred for other services provided. I acknowledge and agree to pay the following **Administrative Fees** should they be incurred on my account. Administrative Fees are as follows: **\$25.00 Cancellation Fee or NO SHOW Appointment Fee for a check-up appointment (Please call within 24 hours to cancel any check-up appointment. When patients cancel the same day of their appointment or simply NO SHOW this takes away our ability to see another patient who needs to be seen). \$35.00 NSF/Returned Check Fee. \$5.00 Form Fee for processing of forms requested by me (blue forms, shot records, sports physical forms, camp forms etc...). \$25.00 FMLA Form fee.**

I agree to pay **33% of the unpaid balance for collections costs**, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court. I further understand that payment is due at time of service and my child may not be seen if my account is in collections.

I hereby waive all rights to claim exemption of personal property and wages from execution, garnishment or attachment pursuant to a lawful judgment otherwise granted to me under the laws and constitutions of the State of Alabama and the United States.

In cases where parents are not married, divorced and/or separated, the person bringing the child in for services will be obligated to pay for any co-pays or balances that are due at the time of service. The legal guardian and /or the person bringing the child in for services will be held responsible for paying any balance resulting from that visit. If legal documentation is presented that someone other than the legal guardian is financially responsible, and accurate billing information can be provided, we will attempt to bill that party. Ultimately, in the State of Alabama, both biological parents are responsible for debts incurred by their minor children.

You may use your MasterCard, Visa, Discover and AMEX to charge current services or any outstanding balance on your account. For your convenience, credit card payments can be made via our website and Patient Portal.

Signature of Parent/Guardian: _____ Date: _____
(My signature states that I agree to financial responsibility)

The responsible party understands that no oral or written contract exists which designates by name or description the individual who will treat the patient. I understand that any release of information or consent to treat other than the authorizations listed above will require my written or verbal approval.

Signature of Parent/Guardian: _____ Date: _____

Mother's Place of Employment: _____ Work Phone Number: _____

Mother's SSN: _____

Father's Place of Employment: _____ Work Phone Number: _____

Father's SSN: _____

HIPAA Notice of Privacy Practices

I have received a copy of Redmont Pediatric Associates, P.C. Notice of Privacy Practices. I am aware that this office is HIPAA compliant and is following federally regulated guidelines regarding my protected health information.

Signature of Parent: _____ **Date:** _____

Signature of Patient (Age 16-19): _____ **Date:** _____

Consent for Use and Disclosure of Protected Health Information

I hereby consent for Redmont Pediatric Associates, P.C. to use or disclose information about me or my child (or another person for whom you have the authority to sign) that is protected under federal law for the purposes of treatment, payment and healthcare operations. Due to recent changes involving federal laws regarding patient privacy, our authorizations are more extensive than ever before. Please understand that the goal of Redmont Pediatric Associates, P.C. is to administer the best medical care available in the most efficient manner. We will always strive, to the best of our ability, to protect the privacy of our patients. Please understand that in the normal course of running our medical office, discussions can sometimes be overheard. Ask at any time if you would like to assure a totally confidential discussion with one of the doctors, lab technicians, nurses or business staff members.

Please carefully read the authorizations below and sign appropriately.

I hereby authorize Redmont Pediatric Associates, P.C. to communicate information to any referring or consulting physician, to any medical facility or to my insurance carrier by facsimile, electronic transmission, telephone or U.S. mail. My personal information is protected under federal law and I have the right to revoke this consent at any time. By signing below, I recognize that the protected health information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

****Signature of Patient or Parent:** _____ **Date:** _____

(If under age 16, must be signed by parent or guardian)**

For Adolescent Patients Ages 16-19 ONLY!!!

I hereby authorize the physicians of Redmont Pediatric Associates, P.C. to discuss my medical condition and treatment plan with my parent or guardian. I understand that if financial responsibility is assumed by my parent or guardian, they will have the right to review services rendered. I have the right to ask for a private consultation with my physician at any given time.

Signature of Patient Ages 16-19: _____ **Date:** _____

Authorization To Bring Patient For Medical Treatment

I give my consent for medical treatment from the physicians of Redmont Pediatric Associates, P.C. I also authorize the following individual to bring my child for medical treatment or call to speak to a doctor or nurse for medical advice. In case of any emergency, I may be reached by telephone for verification if the person accompanying the patient is not named below.

(Please list anyone you would authorize to bring your child to the doctor if you or the other parent cannot)

Name	Phone	Relationship to the Patient
_____	_____	_____
_____	_____	_____

Redmont Pediatric Associates, P.C. New Patient Form

The following information is REQUIRED for Redmont to see your child, please fill out entirely!

Patient's Name (first, middle, last): _____

Nickname: _____ Male: _____ Female: _____ Birthdate: _____

Home/Billing Address: _____

Patient's Personal Cell Number if over age 14: _____

Who is financially responsible for this patient: _____

Mom's Name: _____ Mom's SSN: _____

Mom's Cell Phone: _____ Alternate Phone: _____

Mom's Email Address: _____

Mom's Place of Employment: _____ Birthdate: _____

Dad's Name: _____ Dad's SSN: _____

Dad's Cell Phone: _____ Alternate Phone: _____

Dad's Email Address: _____

Dad's Place of Employment: _____ Birthdate: _____

Emergency Contact: _____ Emergency Phone: _____

Insurance Company: _____ Effective Date: _____

Name of Insured: _____ Birthdate: _____

Policy Number: _____ Group Number: _____

Siblings in our practice: _____ Birthdate: _____

_____ Birthdate: _____

Race, Ethnicity and Preferred Language

Patient Name: _____

Date of Birth: _____

Race (feel free to mark More Than One if needed):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Prefers Not To Answer
- White

Ethnicity (please mark only One):

- Hispanic or Latino
- Not Hispanic or Latino
- Prefers Not To Answer

Preferred Language (Please mark only One):

- English
- Spanish
- Prefers Not To Answer
- Other: _____

