PEACE OF MIND PEDIATRICS

5476 Main Street, Suite 104
Del City, OK 73115

New Patient Information (Please Print) **Date** _____

Name _____ Sex/Gender M/F

Birthdate_____ Ethnicity _____

Address_____ Phone _____

City_____ State_____ Zip _____

Parent/Guardian Information

Guardian's name _____ Relationship to patient_____

Birthdate _____ Phone _____ Email _____

Address _____

2nd Guardian's name _____ Relationship to patient_____

Birthdate _____ Phone _____ Email _____

Address_____

Insurance/Payment Information

Primary Policy (insurance company)_____

Address _____ City_____ State_____

Name of Insured _____ Relationship _____ DOB _____

Policy # _____ Group _____ Co-Pay_____

Employer _____ Insurance Home State_____

Secondary Policy (insurance company)_____

Address _____ City_____State_____

Name of Insured _____ Relationship _____ DOB _____

Policy # _____ Group _____ Co-Pay_____

Employer _____

List any Additional Children

Child's name	DOB	Gender	Insurance Card #
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

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CONSENT FOR TREATMENT OF MINOR CHILD

Patient for whom consent is given:

_____ _____

Full Legal Name Birth Date

As the parent(s) of the minor child listed above, I (we) hereby consent to any radiology or lab testing, medical or surgical treatment, or other medical service rendered to my (our) minor child under the care of any qualified physician, as well as any assistant, designee, or employee on the staff of Peace of Mind Pediatrics.
My (our) consent is given in advance of a specific medical diagnosis or treatment that may be required and is given to encourage each physician, as well as any assistant, designee, or employee of Peace of Mind Pediatrics, to exercise his/her best judgment in ordering tests or treatment appropriate to the child's medical needs.

This consent is effective on the date below and will be updated if the medical history or information of the child or parent(s) change.

Emergency Contacts, other than parents:

1: _____ *Phone*: (___) ____ - _____
Relationship to patient:_____
2: _____ *Phone*: (___) ____ - _____
Relationship to patient:_____

Persons Age 18 or over authorized to bring your child(ren) to the physician:

1: _____ *Relationship to patient:* _____
Phone: (___) ___ - _____

2: _____ *Relationship to patient*: _____
Phone: (___) ___ - _____

_____

Signature of Parent/Guardian

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Financial Policies & Procedures

INSURANCE FILED BY THIS OFFICE IS DONE AS A COURTESY. HOWEVER, GUARDIAN IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS THE GUARDIANS' RESPONSIBILITY TO BE AWARE OF THE BENEFITS THAT THEIR INSURANCE PROVIDES FOR VISITS.

- **Copays** and deductibles are due at the time of service. We accept cash, checks, Visa, Mastercard, American Express, and Discover. We request the amount on file with your insurance company's local processing branch.
    - **TRICARE:** You may have copays, cost-share, and/or deductible fees due at the time of service.

- **Insurance Cards** are required for all active policies (primary, secondary, etc.) at every visit. Please inform our office if there are any changes to your insurance, including but not limited to a new member ID number, group number, or subscriber information.
    - **SoonerCare**: A card is not required, but you must provide the member ID# and current mailing address. Failure to do so may result in a loss of coverage.
    - **TRICARE**: Provide the patient or subscriber's military ID and/or benefits card. Cards issued to the spouse will require that you register the Sponsor's ID or social security number.

- **Self-pay patients** are required to pay the balance due at the time of service.

- **Billing Statements** are sent in two ways:
    - **Electronic Notification**: This free feature is provided via text or email. *Please provide a current mobile number with texting capability and a private email address.*
    - **Mailed Personal Letter**: A statement is mailed to you and includes the payment information provided to our office by your insurance carrier.

- **Payment Plans** are offered as a courtesy to our patients in need. Late fees will apply if you fail to meet your scheduled due date, and your account will be sent to collections for non-payment.

- **Auto-Pay** options are available to help you avoid late fees. Maintain your credit card information securely on file with our office.

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- **Collections** procedures go into effect in the event that your balance is unpaid and overdue after three or more monthly statements and you have not contacted us. Once your account is in collections, any further communication concerning your account will be between you and the collection agency.
    - If I have an unpaid Peace of Mind Pediatrics balance and do not make satisfactory payment arrangements, my account may be placed with an external collection agency.
    - I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.
    - In order for Peace of Mind Pediatrics or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Peace of Mind Pediatrics and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using prerecorded/artificial voice message and/or use of an automatic dialing device, as applicable.

- **Correct insurance information** must be on file with our office at all times. You will be responsible for any balance due if you have not supplied our office with the correct insurance information. **We are not required to re-submit insurance claims**, and a fee of up to $25 may be charged for reprocessing costs**.**

- **I acknowledge that I understand the financial policies and procedures.**
- **I request that authorized benefits be paid to Peace of Mind Pediatrics, PLLC.**
- **I further authorize the release of any medical information necessary to process insurance claims or any medical information required for any healthcare-related utilization review, quality assurance activities, or any healthcare professional requiring this information.**

This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Signature:_____Date:_____

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Credit/Debit Card Pre-Authorization Consent

Peace of Mind Pediatrics submits claims to insurance companies as a convenience to our patients. We request authorization to bill a major credit card or debit card for any remaining balance up to $200.00 to cover the amount determined by your insurance to be your responsibility (deductibles, coinsurance, copays, other cost-shares).

This form gives permission for a single transaction and provides authorization for any additional related debits or credits to your account. Upon receipt of an explanation of benefits from your insurance carrier, we will email you your balance. You will then have 72 hours to change your form of payment. After 72 hours, any unpaid portion of your claim up to $200.00 will be billed to your credit/debit card. Should insurance pay in full, your account will **not** be charged.

Please be advised: “If no email address is provided, my card will be charged without a prior paper statement or email notification being sent.”_____**(Initial**)

All credit/debit card information will remain confidential and securely stored by CardPointe. Peace of Mind Pediatrics will not store any banking account data.

I authorize Peace of Mind Pediatrics to charge any and all outstanding balances up to $200.00, after insurance reimbursement or denial, to my credit/debit card. I will not receive a statement if there is no balance due after processing my credit/debit card for payment. I understand my authorization is valid until canceled. Should my insurance pay in full or my claim take longer than 90 days to process, my account will not be charged, and I will receive a paper statement for any remaining balances.

Provided charges cannot be withdrawn for whatever reason, these charges will be added to your account with a $35 chargeback/insufficient funds fee.

Patient (or Guarantor’s) Printed Name **Date**

Patient (or Guarantor’s) Signature

Email

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Insurance Plans

Peace of Mind Pediatrics may file insurance claims on their behalf as a courtesy to our patients.

Peace of Mind Pediatrics is contracted with multiple insurance carriers. However, there may be some individual plans or insurance contracts with which we are neither in-network nor a participating provider. Your insurance verification may allow us to determine your insurance coverage for the date of service.

It is ultimately the patient's (or guarantor's) responsibility to verify and have a thorough understanding of their medical benefits. Peace of Mind Pediatrics recommends consulting with your insurance carrier by calling the member services phone number on your insurance card.

If you have insurance coverage from multiple insurance companies, please submit all insurance cards and advise which card is your primary insurance plan. Failure to do so may result in you being responsible for 100% of billed charges. This includes SoonerCare members whom Medicaid determines to have primary coverage under another insurance company.

I understand that the insurance copay or coinsurance quote given to me is a good-faith estimate and may vary from the actual amount processed on my claim. I understand I am responsible for all charges not reimbursed by my insurance carrier, including charges applied to my plan's deductible or out-of-pocket expenses for the year.

Insufficient Funds

Peace of Mind Pediatrics reserves the right to charge an additional fee of $25.00 for all returned checks. All unpaid insufficient funds will be turned over to a third-party collection agency.

Patient(or Guarantor's) Signature **Date**

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NO-SHOW APPOINTMENT POLICY

Peace of Mind Pediatrics welcomes patients from all walks of life. We strive to provide a professional and respectful service to our patients and parents/guardians. Our goal is to accommodate all of our patients with appointments, whether they are scheduling in advance or requesting a same-day appointment. We require at least 24 hours' notice for all appointment cancellations and rescheduling. All no-show appointments are logged into the patient's medical records.

Each no-show requires a fee of $25. Each patient is afforded 2 no-shows before possible termination from POMP practice. This policy assists in ensuring the best care for all patients. A letter of notification regarding each no-show appointment will be mailed to the responsible party.

Please sign and date this form confirming receipt of this policy. If you have any questions or concerns regarding the no-show appointment policy, please address them to the office manager. Thank you for your cooperation. Thank you for choosing Peace of Mind Pediatrics for your child(ren)'s healthcare needs.

Responsible Party Signature _____

Date _____

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth:

_____

Parent/Guardian Name: _____

Phone #: _____ Work #:

_____

Reason for request:

_____

Date(s) of service needed:

From: _____ To: _____

Parent/Guardian of Minor Child ____ Emancipated Minor ____

I authorize _____ to release

_____ medical records to **Peace of Mind Pediatrics**
(Patient Name)

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. However, please be advised that any revocation will be effective only to the extent we have not already taken action based on your permission. By signing below, you recognize that the protected health information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law. You may refuse to sign the authorization.

Parent/Patient Signature: _____ Date Signed:

_____

The expiration date is one year from the date signed unless otherwise stated: _____* A photocopy or fax of this authorization is as valid as the original.

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or going to our Website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such revocation shall not affect any disclosures we have made relying on your consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient/Guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices, and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the use of their information.
- The Patient/guardian may revoke this Consent in writing at any time, and all future disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent. Without this signed HIPAA consent form, no insurance can be billed on the patient's behalf; therefore, any services must be paid for in full on the same day of service.

This HIPAA Consent was signed by: _____ _____
Signature of patient or guardian Printed name

Relationship to the patient (if other than patient):_____ _____
Please Print Today's Date

Signature of practice representative:_____