IM&PC
INTERNAL MEDICINE & PEDIATRIC CLINIC

CHILD PATIENT INFORMATION SHEET

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Child's Preferred Name To Be Called: _____ **Patient Gender**: ◯ Male ◯ Female

Patient Date of Birth: ____/____/_____ **Marital Status**: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Other

Patient Race: ◯ American Indian or Alaskan ◯ Asian ◯ Black or African American ◯ White ◯ Declined to specify

Preferred Language: ◯ English ◯ Spanish ◯ Other **Is translator needed?** ◯ **Yes** ◯ **No**

Patient Social Security Number: _____

List all contact phone numbers. Please write name of person beside the number that the phone number belongs to and the relationship to the patient. At least one contact phone number is required.

◯ Cell ◯ Work ◯ Home:_____ ◯ Cell ◯ Work ◯ Home:_____

◯ Cell ◯ Work ◯ Home:_____ ◯ Cell ◯ Work ◯ Home:_____

Email Address: _____

We have several different ways we can contact you for appointment reminders. We have a patient portal that we will give you access to as well. **What is your preferred method of contact from us:** ◯ **phone** ◯ **call** ◯ **text** ◯ **email** ◯ **patient portal**

Parent(Guardian) Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Other

Please list the <u>Child's</u> Primary Mailing Address:

_____
MAILING ADDRESS **CITY** **STATE** **ZIP CODE**

Please note that we can now list up to two addresses on an account for contact purposes. However, no more than that can be listed. Only one address will serve as the primary mailing address though and in cases where multiple resources need to get copies of statements, the primary mailing address will need to forward a copy to any other party or the secondary party will need to call requesting a copy. They will be sent a copy only if they have a legal right to receive such a copy. In the state of Mississippi both parents have all rights to medical information of biological child unless the courts have stipulated otherwise.

Please list the Patient's Secondary Mailing Address if applicable:

_____
MAILING ADDRESS **CITY** **STATE** **ZIP CODE**

We can also remind you when it is time for important immunizations. **Do you give permission to remind you of your child's upcoming immunizations?** ◯ **Yes** ◯ **No**

MS State Immunization Registry requires we send them each patient's Mother's Maiden Name. Please complete the following:

Mother's Maiden Name: _____
FIRST NAME LAST NAME

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Parental /Guardian Information. If you are a Legal Guardian instead of the parent, you will be asked for proof of guardianship.

Father's (or Legal Guardian's) Name, Date of Birth and Social Security Number:
_____

Father's (or Legal Guardian's) Address if different from child's primary mailing address:
_____

Father's (or Legal Guardian's) Employer, Employer's Address & Phone Number:
_____

Mother's (or Legal Guardian's) Name, Date of Birth and Social Security Number:
_____

Mother's (or Legal Guardian's) Address if different from child's primary mailing address:
_____

Mother's (or Legal Guardian's) Employer, Employer's Address & Phone Number:
_____

We will require a copy of your driver's license or a valid photo ID and any insurance card that you might want us to file. While we participate with most insurance companies it is your responsibility to know who your company is in network with. We ask that you know that information before your visit and be prepared to pay for services at the time of the visit. We will not file any insurance company without proof of coverage (aka a copy of the card on file). The following needs to be completed even if giving us a copy of your insurance card because this info is not always found on the card but is often needed to file a claim.
Please list your insurance information below:

Policy #1:_____ Policy #2:_____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder DOB & SSN: _____ Policy Holder DOB & SSN: _____

Employer: _____ Employer: _____

Employer's City/State: _____ Employer's City/State: _____

Please give at least one Emergency Contact other than a parent or guardian of minor and Phone Number of that person:

_____

What pharmacy do you use and in what city? _____

If this appointment is for a newborn please complete the following information about the child's birth:

Birth Weight: _____ **Birth Length:** _____ **Time of Birth:** _____

Name of Birthing Facility: _____

Edited: 11/4/2020 4:24 PM Verified By: _____ Scanned By: _____

City of Birth: _____ State of Birth: _____

We would like to know how you heard about us. Please mark all that apply:

☐ Billboard ☐ Blue Mountain College ☐ Community Event ☐ ER Physician/Hospital ☐ Facebook

☐ Family Member ☐ Friend ☐ Instagram ☐ Internet/Website ☐ Magazine ☐ Newspaper

☐ Other Physician ☐ Patient POP ☐ Radio Commercial ☐ TV Commercial ☐ Twitter

☐ Staff of IM&PC Staff Member's Name:_____

☐ Other _____

Edited: 11/4/2020 4:24 PM Verified By: _____ Scanned By: _____

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INTERNAL MEDICINE & PEDIATRIC CLINIC

AUTHORIZATIONS & ACKNOWLEDGMENTS

Patient Name:_____ MRN:_____
First Middle Last

Acknowledgment of Notice of Privacy Practices
Initial Here _____ I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test
Initial Here _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic, to include students of the medical professions. I also consent to any medical procedures, x-ray, laboratory test or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Destruction of X-ray Images/Graphic Data
Initial Here _____ I hereby authorize the entity to retire x-ray images and other graphic data which may be generated during my care (treatment, testing, or otherwise) four years after the time generated if a proper report is in the medical record.

Release of Information
Initial Here _____ I authorize The Internal Medicine and Pediatric Clinic of New Albany, PLLC (IM&PC) to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility
Initial Here _____ I, the undersigned, jointly and severally, in consideration for the services rendered, accept financial responsibility and agree to pay The Internal Medicine and Pediatric Clinic of New Albany, PLLC (IM&PC) for its charges for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay attorney fees, interest, court cost and other collections costs and expenses. I also understand that should this account be referred to collections, I, and my family member(s) tied to this account, will be terminated as a patient from IM&PC and need to seek medical attention elsewhere. I further authorize any overpayment due me on this account to be applied to any other outstanding balance that I may owe IM&PC.

Initial Here _____ I transfer and assign to IM&PC and to any applicable physician, all rights to benefits payable to me or to a beneficiary. By this assignment, I authorize payment directly to IM&PC and directly to the rendering provider. I understand and agree that if any part of my account is not paid by insurance, for whatever reason, I am still financially responsible for the indebtedness. It is my responsibility to take the action necessary for such benefits to be paid to IM&PC or the physician.

Valid Identification
Initial Here _____ I will provide valid proof of identification to IM&PC at the time of service. I understand that IM&PC will not share this information with any outside source and uses this information to verify my insurance. I further understand that if I cannot provide valid proof of identification at the time of service, then my appointment will be rescheduled until such time proof can be provided.

Patient Portal
Initial Here _____ I acknowledge that a Patient Portal User Name and Temporary Password will automatically be assigned to me. It is at my discretion as to whether the account is ever activated or not. I understand that I may access this account even if I do not have an active email address by logging on to any computer that has internet access and going to www.impcna.com , clicking on Patient Portal and following the prompts to login. I further understand that my temporary password is only good for the initial login, at which time I will have to change my password.

_____ _____
Signature of patient/parent/guardian/person authorized to sign for patient Date

The Internal Medicine and Pediatric Clinic of New Albany, PLLC - Financial Policy

Thank you for choosing us as your health care provider. The following is our Financial Policy. We ask that all patients or patient's responsible party read and sign our Financial Policy prior to receiving services. Our main concern is that you receive proper and optimal treatment needed to restore your health. ***IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR FINANCIAL POLICY, PLEASE DO NOT HESITATE TO ASK US ABOUT IT. YOU MAY CONTACT THE BUSINESS OFFICE BY CALLING (662)534-0898.***

THE FINANCIAL AGREEMENT

We must emphasize that as providers, our relationship is with you, not your insurance company. We do have set contracts in place with certain insurance companies and as such have to abide by some rules and structures. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. We cannot know the individual benefits for every insurance company.

Initial Here: _____

INSURANCE

Payment for services is due at the time services are rendered, except as outlined as follows. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide accurate and timely insurance information. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment. **It is your responsibility to find out what is covered ahead of time.**

PRECERTS – AUTHORIZATION - REFERRALS

Your insurance company may require pre-certification, prior authorization, or referral for some services, such as: radiology, surgery, or specialist visits. Receiving prior authorization does not guarantee that your insurance company will pay for it. Patients have the responsibility to ensure that prior authorization is obtained prior to services rendered.

Initial Here: _____

ASSIGNMENT OF BENEFITS:

To the extent there is third party coverage for payment of services, you agree that all medical and related benefits paid by payer will be irrevocably assigned to The Internal Medicine and Pediatric Clinic of New Albany, PLLC on your behalf.

Initial Here: _____

WORKERS COMPENSATION INJURY:

If you believe you are being seen for an injury/illness as a result of your job, we must have written authorization from your employer to confirm this, and directions from your employer regarding who we should bill for this service. If we do not have this information at the time services are provided, we will bill you and/or your insurance company.

Initial Here: _____

ACCIDENTS AND MOTOR VEHICLE INJURIES:

We will **NOT** file claims for third party payers for motor vehicle accidents. In all cases you bear the responsibility for these costs and must pay them promptly at the time of service. We will provide you with an itemized bill for you to present to the third party payer so that you may be reimbursed by them.

Initial Here: _____

MEDICARE AGREEMENT:

If you have Medicare coverage, you acknowledge that payment of benefits will be made to you or on your behalf for any services furnished to you by The Internal Medicine and Pediatric Clinic of New Albany, PLLC (or the party who accepts assignment), including your physician services. You authorize any holder of medical or other information about you to release to Medicare and its agents, any information needed to determine these benefits or any benefits for related services.

Initial Here: _____

MEDICAID AGREEMENT:

If you have Medicaid coverage, you acknowledge that Medicaid will only cover 12 outpatient visits, not to include wellness visits, per fiscal year. Medicaid's fiscal year runs from July 1st of a calendar year to June 30th of the following calendar year. **THIS POLICY IS SUBJECT TO CHANGE BASED ON MEDICAID REGULATIONS AND GUIDELINES.**

Initial Here: _____

PAYMENT IS YOUR RESPONSIBILITY:

Our relationship is with you, to provide quality healthcare to you and/or your dependent. Consequently, all charges incurred are your responsibility. The obligation to ensure payment in a timely manner lies with you. Unfortunately, we cannot always depend on your insurance company to make timely payment on your behalf. We are not responsible for delays, misplaced claims, or the need for additional information from you by your insurance company. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any question you may have regarding your coverage. All co-payments, deductibles and known co-insurance amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure on our part to collect co-payments, deductibles and co-insurance amounts from patients can be considered fraud.** Please help us in upholding the law by paying your co-payment at each visit. IM&PC now offers Credit Card on file to help deal with the uncertainties due to insurance coverage and to provide a convenient way to pay balances. Should you not have a credit card IM&PC also partners with Care Credit. If neither of these are viable options, then you will be asked to reschedule your appointment to such a time that you will be able to make your copayment.

Initial Here: _____

BILLING INFORMATION:

We will make every effort to submit claims to your insurance company and promptly provide you with our statements. We offer electronic statements which are available on your patient portal. If we receive returned mail because of a problem with an address you provided, you may be dismissed in accordance with these policies, terms, and conditions and referred to a collection agency. To avoid this, please ensure that all of your information is accurate, current, and up-to-date. Please be sure to bring your government-issued photo identification and your insurance cards to every visit so that we may properly bill your insurance company.

Initial Here: _____

PAYMENT GUARANTEE:

For services rendered by The Internal Medicine and Pediatric Clinic of New Albany, PLLC, you guarantee payment of your account at the time services are provided for any and all costs. You acknowledge that if your dependent is provided services you will be responsible for payment under these same policies, terms, and conditions. The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Initial Here: _____

MAKING PAYMENTS:

Patients may pay by cash, money order, check or credit cards (MasterCard, Visa, Discover, American Express or Care Credit) to pay from your "flexible spending account" and/or "health savings account". As of January 1, 2019, we require patients to keep a credit card on file. This is a secure process and is easily set up. Patients agree that if they have a credit balance after paying for a service The Internal Medicine and Pediatric Clinic of New Albany, PLLC can apply it to any outstanding balances on their account. Outstanding balances are due within 30 days, unless prior arrangements have been made with the billing department. Any balance that remains outstanding for more than 90 days will be forwarded to an outside collection agency. If your account is forwarded to a collection agency, we will dismiss you and your immediate family members from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis. Immediate family members may be defined as anyone living in your household or under your care.

RETURNED CHECKS

A $25 fee will be charged for all returned checks and your account will be placed on a "cash-only" basis. We will accept payments only by cash or credit card until the balance is cleared. Should you have another returned check then you will be placed on a permanent "cash-only" basis and we will never accept a check from you again.

Initial Here: _____

TERMINATION OF SERVICES:

If you do not respond to 3 notices to the address we have on file, you agree that The Internal Medicine and Pediatric Clinic of New Albany, PLLC may terminate your relationship. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual provider.

Initial Here: _____

FORMS AND FEES:

There is a $5 per page prepayment fee for the review and completion of any type of form that the patient submits to the clinic. We **DO NOT** keep copies of forms on file in our office. If we have to complete the form again you will have to pay again. Forms are completed for those whose accounts are in good standing. Delinquent accounts must be brought current before forms will be released. Forms must be paid for before they are released.

There is a fee for the copying and transferring of medical records. We will be happy to provide the medical records free of service as a provider courtesy to any provider you are transferring to should you be dismissed from the clinic, move out of state or have been referred to by one of our providers for additional services. Should you require our office to print a copy of your records for your personal use, you will be required to pay the maximum legal fee set by the state of Mississippi. You may always access your records for free through the Patient Portal if you have subscribed for this service while being a patient in good standing in our clinic. Patient Portal is a free service that can be set up through the front office staff at the clinic.

Initial Here: _____

COMMUNICATIONS REGARDING MY ACCOUNT:

I agree that The Internal Medicine and Pediatric Clinic of New Albany, PLLC or any other collection or servicing agency or agencies retained by The Internal Medicine and Pediatric Clinic of New Albany, PLLC (together referred to hereafter as "collectors") to collect any money that I owe to The Internal Medicine and Pediatric Clinic of New Albany, PLLC may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to The Internal Medicine and Pediatric Clinic of New Albany, PLLC, or is otherwise associated with my account.

Initial Here: _____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

IM&PC
INTERNAL MEDICINE & PEDIATRIC CLINIC

AUTHORIZATION TO LEAVE MESSAGES AND DISCLOSE HEALTHCARE INFORMATION

Patient Last Name_____ First Name_____ Middle Initial____ Suffix____ (Jr/Sr/III, etc.)

Address_____ City_____ State_____ Zip_____

Date of Birth_____/_____/_____ Social Security Number_____

Which of the following ways of communication are appropriate/acceptable for IM+PC to communicate with you: (please check all that apply)

☐ Home phone number	☐ Okay to leave a message?	☐ Yes	☐ No
☐ Cell phone number	☐ Okay to leave a message?	☐ Yes	☐ No
☐ Work phone number	☐ Okay to leave a message?	☐ Yes	☐ No
☐ Email address on file	☐ Okay to send a message?	☐ Yes	☐ No

With whom may we share information about your health? Please list below.

Note: In order for IM&PC to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed here: 1. Last 4 digits of patient's social security number 2. Patient's date of birth 3. Patient's current address on file

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to Patient	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Information
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Do you wish to give another access to your patient portal? If so, please indicate to whom access may be given . _____

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name_____ Relationship to Patient_____

Type of document you have: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: _____ Date: _____

IM&PC

INTERNAL MEDICINE & PEDIATRIC CLINIC

118 Fairfield Dr., New Albany, MS 38652
Phone: (662) 534-0898 Fax: (662) 534-8905

Request for Medical Records

PATIENT NAME: _____

Address: _____

City: _____State:_____Zip:_____

Social Security #: _____Patient's Date of Birth: _____

Contact Phone #: _____ Email: _____

MEDICAL INFORMATION OR RECORDS BEING REQUESTED:

_____

FOR THE PURPOSE OF:

_____

NAME AND ADDRESS TO WHOM INFORMATION NEEDS TO BE SENT:

_____

Internal Medicine & Pediatric Clinic of New Albany

118 Fairfield Dr. New Albany, MS 38652

FAX # TO WHOM INFORMATION NEEDS TO BE SENT: _____

NAME OF CLINIC OR DOCTOR INFORMATION IS BEING REQUESTED FROM AND ADDRESS AND PHONE NUMBER OF DOCTOR OR CLINIC:

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

Form Revised 2/7/2019