BROOKWOOD FAMILY PRACTICE AND PEDIATRICS

PATIENT'S NAME_____DOB_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____ALTERNATE PHONE_____

FATHER NAME _____SS#_____DOB_____

MOTHER NAME _____SS#_____DOB_____

ADDRESS(If different than above)_____

STATE_____ZIP_____PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____SUBSCRIBER_____

ID#_____GROUP#_____PHONE_____

SECONDARY INSURANCE_____SUBSCRIBER_____

ID#_____GROUP#_____PHONE_____

EMERGENCY CONTACTS

NAME_____RELATIONSHIP_____

PHONE_____

NAME_____RELATIONSHIP_____

PHONE_____

I hereby authorize Brookwood Family Practice and Pediatrics to release any and all information necessary for filing claims for services I received to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment of benefits directly to Brookwood Family Practice and Pediatrics for services rendered by them.

SIGNATURE_____DATE_____

BROOKWOOD FAMILY PRACTICE AND PEDIATRICS

PATIENT'S NAME_____DOB_____

Age_____DOB_____ School grade_____

Reason for visit_____

Past Medical History

Birth weight_____Birth length_____

Term or Pre-term_____Caesarian or vaginal_____

Complications_____

Drug Allergies_____

Current medications_____ _____

_____ _____

_____ _____

Herbals/Vitamins _____ _____

Past Medical problems_____ _____

_____ _____

Surgeries _____ _____

_____ _____

Social History

Smoke exposure in home _____

Hours of video games/tv/computer daily _____

School performance _____

Exercise and amount daily _____

Vaccination History

(Please provide copy of vaccination records if possible)

BROOKWOOD FAMILY PRACTICE AND PEDIATRICS

FAMILY HISTORY

(Please include any history of heart disease, cancer, or high cholesterol)

Mother_____

Father_____

Siblings_____

Review of Symptoms

(Over the past six months, has your child had any problems with the following)

	No	Yes	(if yes, describe)
Skin	_____	_____	_____
Chronic headaches	_____	_____	_____
Eye	_____	_____	_____
Ears	_____	_____	_____
Allergies	_____	_____	_____
Nose	_____	_____	_____
Gums/mouth	_____	_____	_____
Swollen glands	_____	_____	_____
Breasts	_____	_____	_____
Breathing	_____	_____	_____
Heart	_____	_____	_____
Stomach	_____	_____	_____
Bowels	_____	_____	_____
Genitalia	_____	_____	_____
Nerves	_____	_____	_____
Mood	_____	_____	_____
Joints/muscle	_____	_____	_____
Weight changes	_____	_____	_____

BROOKWOOD FAMILY PRACTICE AND PEDIATRICS

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. 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-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 questions you may have regarding your coverage.
2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services:** Please be aware that some –and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to collection agency and you and your immediate family members may be discharged 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 physician will only be able to treat you on an emergency basis.
8. **Missed appointments:** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

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

BROOKWOOD FAMILY PRACTICE AND PEDIATRICS

Consent for the Use and /or Disclosure of Protected Health Information

I hereby give consent to the office practice of Brookwood Family Practice and Pediatrics to use and disclose my (or my child's) protected health information for the purposes of treatment, payment, and healthcare operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by asking the receptionist for the most recent copy.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding to us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to our office. It will become effective once received and agreed upon. Your revocation will not be effective to the extent that we (or others) have acted in retrospect upon this consent.

_____ _____

Signature of Patient of Legal Guardian Date

_____

Printed Name of Patient or Guardian