Gulf Coast Children's Clinic

Today's Date: _____

PATIENT INFORMATION

This is an official office document that needs to be filled out completely by Parent/Legal Guardian

Name: _____ DOB: _____
(Last) (First) (Middle)

Sex: M / F Birth Hosp: _____ Mother's Maiden name: _____

Phone (1): _____ Phone (2): _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Race: Black / Asian / White / Spanish / Declined / Other: _____
Ethnicity: Non-Hispanic / Hispanic / Declined / Other: _____
Patient lives with: Mother / Father / Both Parents / Legal Guardian

MOTHER/LEGAL GUARDIAN

*Full Name: _____ *DOB: _____ *Social: _____

*Cell #: _____ Home #: _____ Work #: _____

Employer: _____ Employer Address: _____

FATHER/LEGAL GUARDIAN

*Full Name: _____ *DOB: _____ *Social: _____

*Cell #: _____ Home #: _____ Work #: _____

Employer: _____ Employer Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

CONSENT TO TREAT

A parent or legal guardian must be at the very first visit, NO EXCEPTIONS. If someone other than the parent is the legal guardian, they must bring proof of guardianship. Children under the age of 18 must be accompanied by an adult.

Parent/Legal Guardian Signature: _____ **Date:** _____

INSURANCE INFORMATION

Copays, Deductibles or Coinsurances are DUE AT THE TIME OF SERVICE
(*Indicate required field)

***Primary Insurance:** _____ *Policy Number: _____

Group Number: _____ Insurance Address: _____

*Subscriber Name: _____ *Date of Birth: _____

***Secondary Insurance:** _____ *Policy Number: _____

Group Number: _____ Insurance Address: _____

*Subscriber Name: _____ *Date of Birth: _____

Gulf Coast Children's Clinic

CONSENT TO FILE INSURANCE

- Any Medicaid entity will be secondary to all private insurance. Not providing the correct insurance could result in termination of insurance benefits, reversal of insurance payment, parental responsibility of payment and possibly collections
- Tricare is secondary to all insurance except any Medicaid entity. (MEDICAID, CHIPS, MSCAN, MAGNOLIA, MOLINA)
- To file insurance, we must have the CARD (front & back), the SUBSCRIBER'S NAME, DATE OF BIRTH and SOCIAL.
- CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE and should be collected from the person bringing the child to an appointment.
- WE CAN ONLY FILE TWO INSURANCES.
- IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS, DEDUCTIBLES, CO-PAYS, ECT.
- When applying for Medicaid for a newborn, please keep in contact with your caseworker. Mom's Medicaid will not pay for the child. THE CHILD SHOULD HAVE THEIR OWN NUMBER BY 30 DAYS OLD.

I agree the insurance information is complete and accurate to the best of my knowledge. I understand it is my responsibility to update insurance at any time this information should change. I hereby assign my insurance benefits to be paid directly to Gulf Coast Children's Clinic. I authorize Gulf Coast Children's Clinic to release medical information required to process my claim for services I received. I authorize Gulf Coast Children's Clinic to pursue any unpaid or incorrectly adjudicated claims.

Parent/Legal Guardian Signature: _____ **Date:** _____

AUTHORIZED ADULTS TO ACCOMPANY PATIENT

(To receive medical information)

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

You may revoke or terminate this authorization by submitting a written revocation. Information that is disclosed under this authorization may be disclosed again by the person or organization which is sent. The privacy of information may not be protected under the federal privacy regulations

I authorize that the above adults may bring my child or seek medical advice if I am unavailable.

Patient Name: _____ **DOB:** _____

Parent/Legal Guardian Signature: _____ **Date:** _____

*****HIPPA POLICY IS POSTED IN OFFICE AND YOU MAY REQUEST A COPY AT ANY TIME*****

SIBLINGS WITHIN SAME HOUSEHOLD

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Gulf Coast Children's Clinic

OFFICE POLICIES

Please READ & SIGN

VACCINE POLICY (NO EXCEPTIONS)

- GCCC FOLLOWS CDC GUIDELINES FOR VACCINE COMPLIANCE AND RECOMMENDATIONS. IF YOUR ARE NOT WILLING TO KEEP VACCINES COMPLIANT OR CHOOSE NOT TO VACCINATE, WE CANNOT CONTINUE CARE AND PUT OTHER PATIENTS AT RISK. *(Does NOT include Covid-19 Vaccine)*

Signature: _____

APPOINTMENT POLICY

- We try to schedule every patient with consideration of your day, doctor, time and office preference. Please let us know if you have a specific preference. For same day appointments, you may be given a "work in appointment", which may be a little longer wait. Please understand sometimes unforeseen things come up in the back and may cause clinic or a specific provider to get behind. Just know we are giving every patient the best quality care we can, as all our patient are equally important.
- If a sibling needs to be seen in addition, we will do our best to "work them in".
- If you are more than 15 MINUTES LATE for the appointment time, it will be at the provider's discretion to reschedule. We understand things unexpectedly come up. Please call if you know you may not make your appointment time.

Signature: _____

BILLING POLICY

- Please make the office aware of any address, phone, insurance or guardianship changes, as to keep up with referrals, reminders, billing and any need to reach a parent. We must obtain a YEARLY update for all patients. The form may be printed from our website or emailed to you to be completed before your appointment if needed.

Signature: _____

SCHOOL EXCUSE POLICY

- We can only excuse a child with an appointment, not a sibling that was not seen. If there is no diagnosis for a child to miss the remainder of the day, the note will be for them to return same day (ADHD, well child or routine physical). Any excuse other than the allotted time for strep or flu will have to go through a doctor. If your child continues to be ill past the excused time, please call ASAP to confirm with a doctor or determine if the child must be seen.

Signature: _____

24 HOUR NOTICE POLICY

- Please give staff 24hour notice for any request such as prescription refills, shot records, nurse calls, ect. FMLA and head start forms may require longer. If any request can be done the same day, we will certainly try.

Signature: _____

OFFICE HOUR PLICY

- Office hours are Monday-Friday from 8am-5pm. (These hours are subject to change). We suggest arriving before/by 4:00pm to pick anything up, as sometimes clinic may finish early. Summertime hours are usually a shorter time, whereas winter hours are usually longer. We always have a provider on call when the office is closed. Please use the on-call provider for medical advice and general medical questions ONLY. Any appointments, requests, billing questions, etc. will have to be handled during available office hours.

Signature: _____

VERBAL ABUSE POLICY

- VERBAL ABUSE, OFFENSIVE LANGUAGE OR DISRESPECTFUL ACTIONS TO ANY OFFICE STAFF WILL NOT BE TOLERATED. YOU MAY BE SUBJECT TO DISMISSAL FROM OUR CLINICS.

Signature: _____

COMMUNICATION CONSENT

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me for calls, texts, emails, and appointment reminders. Also, to contact me regarding my child's care and account by this medical provider and this medical provider's business associates.

Patient's Name: _____ **DOB:** _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Gulf Coast Children's Clinic

FINANCIAL POLICY

- All payments are due at the time of service including deductibles, co-pays, or co-insurance/percentages.
- Insurance provided at the time of service will be filed as a courtesy. All necessary information to electronically file a cla must be presented by the parent/legal guardian.
- We will NOT BACK FILE A SECONDARY INSURANCE AFTER A VISIT. If secondary insurance is presented at the time of ser it will be filed after the primary insurance has processed claims.
- If your insurance company does not pay in a timely manner, we will look to you for payment. If we later receive paym from your insurer, we will refund any overpayment to you.
- We cannot change a diagnosis to make a service covered. (i.e., sports physical, well child, or reason for labs).
- Combined visits may not be covered by some insurances. (Well child vs. any other concerns; as well, these visits are scheduled according to allotted time needed.)
- We will bill your insurance for any hospital services provided by our physicians. You will be responsible for any balance
- We understand families may undergo financial hardships. We do offer payment plans for past due balances (they do n apply to same day services such as no insurance at the time of visit). No payment plans will be given to amounts unde $100. If your payment plan defaults, the balance will be due in full. Failure to pay may result in further collection actio suspended services until account is resolved.
- We send statements monthly and try to remind you at the time of service of any past due balances. You must notify u any billing or address changes.
- Accounts are subject to collection after 90 days past due (from date of service). The collection agency typically adds a fee.
- If your account is turned over to an outside collection agency, we cannot schedule any appointments or provide any s for the family accounts until paid out through the collection agency, including any fees that may incur.
- Administrative fees will be incurred for request of medical records and completion of FMLA paperwork ($20 per insta required paperwork).

I agree to pay for any and all medical services I receive from this practice that my insurance company denies payment for what reason (e.g. non covered services that may include, but are not limited to: vaccines, developmental screening, vision/hearing screening, strep/flu test, urine dips, or preventative care visits.) I will pay for the balance upon written/verbal notice of their de further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encou and documented in their medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

I authorize the release of any medical information necessary to process any claim to any parties requestion this information, n included. I acknowledge I have read and understand this financial policy and my request a copy for my own records. Policy is s to change.

Patient Name: _____ DOB: _____

Printed Parent/Legal Guardian: _____

Signature: _____ Date: _____

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