Gulf Coast Children's Clinic, P.A.

Infant • Child • Adolescent

OBAID SIDDIQUI, M.D. FAAP
TIJUANA L FREEMAN, M.D.
JOANNA DUPONT, M.D., FAAP
CARRIE GRANT, PA-C
FAUZIA QUDDUS, M.D., FAAP
KIMBERLY BROWN, M.D. FAAP
KENDRA WATTS, CPNP
CHERISH CAMPBELL, CPNP
TRISHNA SISODRAKER, M.D. FAAP
KELLY NATION, M.D., FAAP

Date: _____.

INFORMATION MUST BE FILLED OUT *COMPLETELY* BEFORE WE CAN MEET REQUIREMENTS FOR OUR ELECTRONIC MEDICAL RECORDS TO PROVIDE OFFICE SERVICES.

CHILD'S FULL NAME: _____
LAST *FIRST* *MIDDLE*

STREET ADDRESS: _____
STREET ADDRESS: *APT#:* *CITY:* *STATE:* *ZIP:*

PHONE 1: _____ PHONE 2: _____ ALLERGIES: _____

DATE OF BIRTH: _____ SEX: _____ BIRTH HOSPITAL/DR. _____

EMERGENCY CONTACT: _____
E-MAIL ADDRESS***REQUIRED**_____

OPTIONAL: RACE, LANGUAGE, AND ETHNICITY ARE OBTAINED SOLELY FOR THE PURPOSE OF THE FEDERAL GOVERNMENT ELECTRONIC MEDICAL RECORDS AND NOT REQUIRED BY GULF COAST CHILDREN'S CLINIC.

RACE: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ DECLINED ☐ OTHER
ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC ☐ DECLINED
LANGUAGE: ☐ SPANISH ☐ ENGLISH ☐ OTHER _____

WE MUST HAVE PARENT INFORMATION FILLED OUT COMPLETELY TO ATTACH A "GUARANTOR" TO THE PATIENT AND FOR ANYONE ELSE WHO HOLDS INSURANCE. ***NO EXCEPTIONS***.

MOTHER'S NAME: _____ EMPLOYER: _____
(LEGAL GUARDIAN)
DATE OF BIRTH: _____ EMPLOYER ADDRESS: _____

SSN: _____ EMPLOYER PHONE: _____

FATHER'S NAME: _____ EMPLOYER: _____
(LEGAL GUARDIAN)
DATE OF BIRTH: _____ EMPLOYER ADDRESS: _____

SSN: _____ EMPLOYER PHONE: _____

INSURANCE #1:
NAME OF INSURED: _____ INSURANCE: _____

INS DOB: _____ POLICY/ID#: _____

INS SS#: _____ GROUP #: _____

INSURANCE #2:
NAME OF INSURED: _____ INSURANCE: _____

INS DOB: _____ POLICY/ID#: _____

INS SS#: _____ GROUP #: _____

THANK YOU FOR SELECTING US TO MEET YOUR HEALTHCARE NEEDS AND PROVIDING US WITH ALL NECESSARY INFORMATION. INSURANCE CARDS MUST BE PROVIDED AT TIME OF SERVICE. WITHOUT CARDS, WE HAVE NO INFORMATION TO SEND OUR CLAIMS (FILED THE SAME DAY ELECTRONICALLY), OR TO VERIFY ELIGIBILITY.

NO CARD - NO INSURANCE. THERE ARE NO EXCEPTIONS.
ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

Gulf Coast Children's Clinic, P.A.

Infant • Child • Adolescent

OBAID SIDDIQUI, M.D. FAAP
TIJUANA L FREEMAN, M.D.
JOANNA DUPONT, M.D., FAAP
CARRIE GRANT, PA-C
FAUZIA QUDDUS, M.D., FAAP
KIMBERLY BROWN, M.D. FAAP
KENDRA WATTS, CPNP
CHERISH CAMPBELL, CPNP
TRISHNA SISODRAKER, M.D. FAAP
KELLY NATION, M.D., FAAP

- Parent or Legal Guardian must be present with children under the age of 18 years old. If legal guardian is not the mother or father, the guardian must bring proof of guardianship. NO EXCEPTIONS!
- Patient must have their insurance card. The number alone is not sufficient. If you do not have your insurance card, please be prepared to pay at the time of service or reschedule the appointment.
- If office policies are not followed, the patient will not be seen. They are welcome to call the office prior to the appointment with any questions.

(RELEASE OF INFORMATION)

(PLEASE INITIAL EACH PARAGRAPH)

*_____ I authorize any physician to release all information available as to diagnosis, treatments, or prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to the insurance company and/or its representatives. Assignment of benefits is allowed as designated by this office.

*_____ I authorize verification of any and/or all facts included within this registration form to be released to GULF COAST CHILDREN'S CLINIC for collection purposes only. I authorize GULF COAST CHILDREN'S CLINIC to obtain credit reports as necessary. A photocopy of this authorization is to be considered the original.

(PAYMENT POLICY)

*_____ Payment is due when services are rendered. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of the insurance coverage. It is customary to pay for service requiring the aid of an attorney, collection agency, credit bureau, or court. 40% service will be added to the patient's unpaid balance.

(INSURANCE CLAIMS POLICY)

*_____ I authorize GULF COAST CHILDREN'S CLINIC to furnish information to insurance carriers concerning any illness and treatment. I assign to the physician all payments for medical services rendered to my dependents and myself.

*___ I UNDERSTAND AND AGREE I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE CARRIER.

Insurance claims are filed as a courtesy service. The patient is responsible for all fees, regardless of insurance coverage, and for handling all insurance claim problems.

(PPO PATIENTS)

Our contract with the PPO requires us to accept the established co-pay at the time services are rendered. Consequently, we cannot bill our PPO patients for any portion of the co-pay.

I agree this authorization is valid until rescinded in writing or replaced at a later date. I understand all policies explained above.

DATE: _____SIGNED**:** _____

(PARENT/LEGAL GUARDIAN)

Gulf Coast Children's Clinic, P.A.

Infant • Child • Adolescent

OBAID SIDDIQUI, M.D. FAAP
TIJUANA L FREEMAN, M.D.
JOANNA DUPONT, M.D., FAAP
CARRIE GRANT, PA-C
FAUZIA QUDDUS, M.D., FAAP
KIMBERLY BROWN, M.D. FAAP
KENDRA WATTS, CPNP
CHERISH CAMPBELL, CPNP
TRISHNA SISODRAKER, M.D. FAAP
KELLY NATION, M.D., FAAP

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for your child and we want you to completely understand our financial policies.

1. Payment is due at the time services are rendered unless your carrier has made other arrangements in advance. We do accept all major credit cards.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later received a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plan to accept an assignment of benefits. We will bill them, and you are required to pay a co-pay at the time of service.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore any charges for your care are due at the time of service.
5. Not all insurance plans cover all services. If your insurance plan determines a service will not be covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practices financial policy and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

(Signature of responsible party) **DATE**

(Please print the name of the patient)

Gulf Coast Children's Clinic, P.A.

Infant • Child • Adolescent

OBAID SIDDIQUI, M.D. FAAP
TIJUANA L FREEMAN, M.D.
JOANNA DUPONT, M.D., FAAP
CARRIE GRANT, PA-C
FAUZIA QUDDUS, M.D., FAAP
KIMBERLY BROWN, M.D. FAAP
KENDRA WATTS, CPNP
CHERISH CAMPBELL, CPNP
TRISHNA SISODRAKER, M.D. FAAP
KELLY NATION, M.D., FAAP

(HIPAA LAW ACKNOWLEDGMENT FORM)

The following is in compliance with the HIPAA law effective April 1, 2003.

(Privacy policy)

We understand that medical information is personal. We maintain a record of care and services provided that complies with legal requirements. This acknowledgement form applies to all of the records of your child's care that we maintain. Law requires us to:

- Keep medical information about you private.
- Give you notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

We may change our policies at any time. Changes will apply to medical information we already possess as well as new information we receive after any change occurs. We may use and disclose medical information about your child's treatment (such as sending medical information to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicaid); and to support healthcare operations (such as comparing patient data to improve treatment methods).

We may use or disclose medical information about your child without your prior authorization for several reasons. Subject to certain requirements, we may give out medical information about your child without authorization for public health purposes, abuse or neglect reporting, health oversight audits, or inspections, research studies, and emergencies. We also disclose medical information when required by law, such as in response to requests from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

In other situations not covered by this notice, we will ask for your written authorization before using or disclosing medical information. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing about your decision.

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY POLICIES

I have reviewed this office's **Notice of Privacy Policies**, which explains how my medical information will be used and disclosed.

Patient name: _____

Parent/legal guardian (printed): _____

Parent/legal guardian signature: _____ **Date:** _____

Gulf Coast Children's Clinic, P.A.

Infant • Child • Adolescent

OBAID SIDDIQUI, M.D. FAAP
TIJUANA L FREEMAN, M.D.
JOANNA DUPONT, M.D., FAAP
CARRIE GRANT, PA-C
FAUZIA QUDDUS, M.D., FAAP
KIMBERLY BROWN, M.D. FAAP
KENDRA WATTS, CPNP
CHERISH CAMPBELL, CPNP
TRISHNA SISODRAKER, M.D. FAAP
KELLY NATION, M.D., FAAP

MEDICAL CONSENT

I, _____, parent/legal guardian of _____
(PARENT/LEGAL GAURDIAN) **(PATIENT NAME)**

Do hereby give consent to any medical care/treatment determined by any medical staff of Gulf Coast Children's Clinic to be necessary for the welfare of my child. If the parent or legal guardian(s) are not available, I hereby authorize the names I provide below to make informed medial decisions for the health/welfare of the child. I also understand it is **MY** responsibility as parent/legal guardian to provide any/all information necessary to the child's health/welfare to the below mentioned care seekers, So that the patient receives the best care possible. This includes any proof of insurance, co-pays, and deductibles.

NAME & CONTACT NUMBERS FOR AUTHORIZED VISITS/INFORMATION REGARDING MY CHILD

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

I have read and understand/agree to all policies and procedures of Gulf Coast Children's Clinic.

Signed: _____
(Parent/legal guardian only)

Date: _____

Relationship to patient: _____

Gulf Coast Children's Clinic, P.A.

Infant • Child • Adolescent

OBAID SIDDIQUI, M.D. FAAP
TIJUANA L FREEMAN, M.D.
JOANNA DUPONT, M.D., FAAP
CARRIE GRANT, PA-C
FAUZIA QUDDUS, M.D., FAAP
KIMBERLY BROWN, M.D. FAAP
KENDRA WATTS, CPNP
CHERISH CAMPBELL, CPNP
TRISHNA SISODRAKER, M.D. FAAP
KELLY NATION, M.D., FAAP

DATE: _____

PATIENT'S NAME: _____ DOB: _____

★★MOTHER'S INFORMATION ONLY NEEDED IF CHILD IS UNDER 30 DAYS OF AGE AND YOU HAVE NOT RECEIVED THE CHILD'S MEDICAID NUMBER★★

MOTHER'S NAME: _____

MOTHER'S MEDICAID NUMBER: _____

I, _____, CERTIFY THAT I AM THE MOTHER OF THE CHILD WHOSE NAME AND DATE OF BIRTH APPEAR ABOVE AND THAT THE CHILD RESIDES IN MY HOUSEHOLD.

SIGNATURE: _____

MEDICAID RECIPIENT'S AUTHORIZATION AND ASSIGNMENT

CHILD'S NAME: _____

CHILD'S MEDICAID NUMBER: _____

CLINIC OR PHYSICIAN'S NAME:_____

Patient's or Authorized Person's Signature:
I certify that the information given in applying for payments under Title XIX of the Social Security Act (Medicaid) is correct. I authorize any holder of medical or other information about me to release to the state of Mississippi or its fiscal agent any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made to the above listed provider on my behalf for services rendered during this period _____ through _____.

Signed: _____

Date: _____