OFFICE POLICIES

**Please read and initial the office policies we would like you to be aware of. **

_______ GCCC FOLLOWS CDC GUIDELINES FOR VACCINE COMPLIANCE AND RECOMENDATIONS. IF YOU ARE NOT WILLING TO KEEP VACCINES COMPLIANT OR CHOOSE NOT TO VACCINATE, WE CANNOT CONTINUE CARE AND PUT OTHER PATIENTS AT RISK. NO EXCEPTIONS.

_______We try to schedule every patient with consideration of your day, doctor, time and office of 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 or first available. Please understand sometimes unforeseen things come up in the back and may cause clinic or a specific doctor to get behind. Just know we are giving every patient the best, quality care we can, as all of our patients are equally important.

_______If you have additional children to be seen or additional concerns not addressed at the time the appointment was made we may need to reschedule to allow sufficient time for providers and minimize delay of appointments following. 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 appointment time it will be at the doctor's discretion to reschedule. We understand things unexpectedly come up, please call if you know you may not make your appointment time.

_______ 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, this may be printed from our website or emailed to you to be completed before your appointment if needed.

_______School excuses have become an issue with schools. 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 again.

______Please give staff 24 hour notice for any request such as prescription refills, shot records, and nurse calls. FMLA and head start forms may require longer. If any request can be done the same day we will certainly try but we cannot back up clinic, doctors, or nurses to complete non- emergent requests.

______Office hours are Monday through Friday 8 - 5, with the Ocean Springs office ONLY open Saturday 8 to 12pm. ***THESE HOURS ARE SUBJECT TO CHANGE*** We suggest arriving by 4:30 to pick anything up, as sometimes clinic may finish early. Summer time 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 medial questions only. Any appointments, requests, billing questions, ETC. will have to be handled during available office hours.

______We offer Webportal access to patient charts. Please ask office staff if you need access or have questions.

______ Verbal abuse, offensive language or disrespectful actions to any office staff WILL NOT BE TOLERATED and you may be subject to dismissal from our clinics.

CHILD'S NAME____ DOB____________________

PARENT SIGNATURE____ DATE__________________

PATIENT INFORMATION DATE:____________

PATIENT LAST NAME	MOTHER'S MAIDEN NAME
PATIENT FIRST NAME	BIRTH HOSPITAL/ DOCTOR
PATIENT MIDDLE NAME	DATE OF BIRTH SEX
ADDRESS APT CITY STATE ZIP EMAIL **REQUIRED FOR WEBPORTAL COMMUNICATION**	REQUIRED BY GOVERNMENT MANDATE (ALTHOUGH YOU MAY REFUSE) **CIRCLE** *RACE* : AFRICAN AMERICAN ASIAN CAUCASIAN HISPANIC DECLINED OTHER *ETHNICITY* : NON-HISPANIC HISPANIC DECLINED *LANGUAGE*: SPANISH ENGLISH OTHER
PRIMARY PHONE	SECONDARY PHONE

PARENT INFORMATION

MOTHER'S FULL NAME (LEGAL GUARDIAN)	EMPLOYER/ ADDRESS
DATE OF BIRTH	WORK PHONE
SSN	CELL

FATHER'S FULL NAME (LEGAL GUARDIAN)	EMPLOYER/ADDRESS
DATE OF BIRTH	WORK PHONE
SSN	CELL

ADDITIONAL SIBLINGS

NAME	DOB
NAME	DOB
NAME	DOB
NAME	DOB
NAME	DOB
NAME	DOB

EMERGENCY CONTACT OTHER THAN PARENT OR GUARDIAN / PHONE NUMBER:

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FINANCIAL POLICY

- All payments are due at the time of service including deductibles, co-pay, co-insurance or percentage.
- Insurance provided at the time of service will be filed as a courtesy. All necessary information to electronically file a claim must be presented by parent or legal guardian.
- We will only file TWO insurances and will be filed according to insurance rules, what insurance deems primary, secondary or order by date of birth.
- We will not BACK FILE a secondary insurance AFTER a visit. If secondary insurance is presented at the time of service, 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 payment from your insurer, we will refund any overpayment to you.
- Not all insurance plans cover all services. If your insurance plan deems a service NON-COVERED, you will be responsible for all charges INCLUDING VACCINES. It is YOUR responsibility to verify your insurance services and coverage.
- We cannot change a diagnosis to make a service covered. (i.e. sports physical, well child, or reason for labs ordered)
- 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 due.
- I authorize GULF COAST CHILDREN'S CLINIC to furnish information to insurance companies concerning any illness any treatment. I assign to the physician all payments for medical services rendered to my dependents and myself.
- We understand families may undergo financial hardships, we do offer payment plans for past due balances. Payment plans do not apply to same day services (i.e. no insurance at the time of an office visit). No payment plans will be given to amounts under $100. If your payment plan defaults, the balance will be due in full. Failure to pay may result in further collection action or suspended services until account resolved.
- We send statements monthly and try to remind you at time of service of any past due balances. You must notify us of any billing or address changes.
- Accounts are subject to collections after 90 days past due (from the date of service). The collection agency typically adds a 40% fee.
- If your account is turned over to an outside collection agency we cannot schedule any appointments or provide any service for the family account 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 instance of required paperwork.

I agree to pay for any and all medical services I receive from this practice that my insurance company denies payment, for whatever reason. This office will file a claim on my behalf; however, if my insurance company denies payment, for whatever reason (e.g., non-covered services that may include but are not limited to vaccines, developmental screenings, vision and hearing screenings, strep test, flu test and urine dips or insurance does not cover for preventive care visits), I will pay for same upon written/verbal notice of their denial. I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in their medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from in insurance carrier is inappropriate and fraudulent.

I authorize the release of any medical information necessary to process any claims to any parties requesting this information, myself included. I acknowledge I have read and understand this financial policy and may request a copy for my own records. Policy subject to change.

_______________________ _______________________ _______________

Signature of Parent/Legal Guardian | Printed Parent/ Legal Guardian | Date

_______________________ _______________________

PATIENT NAME | PATIENT DATE OF BIRTH

INSURANCE INFORMATION

*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 MEDICIAD ENTITY. (MEDICAID, CHIPS, MS CAN, MAGNOLIA)
* TO FILE INSURANCE WE MUST HAVE THE CARD, FRONT AND 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 BY PRESENTING 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, ETC.
*WHEN APPLYING FOR MEDICAID PLEASE KEEP IN CONTACT WITH YOUR CASEWORKER, MOM'S MEDICAID WILL NOT PAY FOR THE CHILD. CHILD SHOULD HAVE THEIR OWN NUMBER BY 30 DAYS OLD.

PRIMARY INSURANCE	POLICY OR ID NUMBER
LAST NAME (POLICY HOLDER)	GROUP NUMBER
FIRST NAME (POLICY HOLDER)	MAILING ADDRESS (INSURANCE)
DATE OF BIRTH (POLICY HOLDER)	CITY STATE ZIP
EMPLOYER NAME	EMPLOYER ADDRESS

SECONDARY INSURANCE	POLICY OR ID NUMBER
LAST NAME (POLICY HOLDER)	GROUP NUMBER
FIRST NAME (POLICY HOLDER)	MAILING ADDRESS (INSURANCE)
DATE OF BIRTH (POLICY HOLDER)	CITY STATE ZIP
EMPLOYER NAME	EMPLOYER ADDRESS

I AGREE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO UPDATE 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 CLAIMS FOR SERVICES I RECEIVED. I AUTHORIZE GULF COAST CHILDREN'S CLINIC TO PURSUE ANY UNPAID OR INCORRECTLY ADJUCATED CLAIMS.

SIGNATURE: ______________________________ ***DATE:*** ______________

CONSENT TO TREAT

Patient Name____ Birthdate____________________

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 age 18 must be accompanied by an adult. I hereby give Gulf Coast Children's Clinic permission to treat my child. I also authorize that the following adults may bring my child or seek medical advice if I am unavailable.*

____

Signature of Patient or Representative | Relationship to Patient | Date

Who would you like to receive the information or accompany your child (who, in your family, you authorize us to speak with. For example, step-parents, girl/boyfriends, babysitters, grandparents.)

____

Name of person | Relationship to patient | Phone number

____

Name of person | Relationship to patient | Phone number

____

Name of person | Relationship to patient | Phone number

____

Name of person | Relationship to patient | Phone number

____

Name of person | Relationship to patient | Phone number

____

Name of person | Relationship to patient | Phone number

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 it is sent. The privacy of information may not be protected under the federal privacy regulations.

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