Gulf Coast Children's Clinic

Patient Registration & Intake

Today's Date: _____

Patient Information

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

Name: Last _____ First _____ Middle _____

DOB: _____ **Sex:** M / F **Birth Hospital:** _____

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 coinsurance are due at the time of service.

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____ Insurance Address: _____

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____ Insurance Address: _____

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 and back), the subscriber's name, date of birth, and Social Security number. Copays 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, and copays. 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: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

You may revoke or terminate this authorization by submitting a written revocation. Information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Privacy of that 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: _____

HIPAA policy is posted in the 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: _____

Office Policies

Please read and sign each section

Verbal Abuse Policy

Verbal abuse, offensive language, or disrespectful actions toward any office staff will not be tolerated. You may be subject to dismissal from our clinics.

Signature: _____ Date: _____

Vaccine Policy

GCCC follows the American Academy of Pediatrics recommendations for vaccines. If you have any questions or concerns about vaccines, please speak to your nurse or pediatrician.

Signature: _____ Date: _____

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 mean a longer wait. Unforeseen events may cause clinic or a specific provider to run behind; we give every patient the best quality care we can. 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. Please call if you know you may not make your appointment time.

Signature: _____ Date: _____

Billing Policy

Please make the office aware of any address, phone, insurance, or guardianship changes so we can keep up with referrals, reminders, billing, and the 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: _____ Date: _____

School Excuse Policy

We can only excuse a child with an appointment, not a sibling who 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 the 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 as soon as possible to confirm with a doctor or determine if the child must be seen.

Signature: _____ Date: _____

24-Hour Notice Policy

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

Signature: _____ Date: _____

Office Hours Policy

Office hours are Monday–Friday from 8:00 a.m.–5:00 p.m. (subject to change). We suggest arriving before/by 4:00 p.m. to pick anything up, as sometimes clinic may finish early. Summer hours are usually shorter; 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. Appointments, requests, billing questions, etc. must be handled during available office hours.

Signature: _____ Date: _____

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, and 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: _____

Financial Policy

- All payments are due at the time of service including deductibles, copays, or coinsurance/percentages.
- 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 the parent/legal guardian.
- 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.
- We cannot change a diagnosis to make a service covered (for example, sports physical, well child, or reason for labs).
- Combined visits may not be covered by some insurers (well child vs. other concerns); 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.
- We understand families may undergo financial hardships. We offer payment plans for past-due balances (they do not apply to same-day services such as no insurance at the time of visit). No payment plans will be given for 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 the 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 us of 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 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 accounts until paid out through the collection agency, including any fees that may incur.
- Administrative fees will be incurred for requests 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 (for example, non-covered services that may include, but are not limited to: vaccines, developmental screening, vision/hearing screening, strep/flu test, urine dips, or preventive care visits). I will pay for the balance upon written or 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. Asking 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 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 is subject to change.

Patient Name: _____ DOB: _____

Printed Parent/Legal Guardian: _____

Signature: _____ Date: _____

Mississippi Division of Medicaid

Rights and Responsibilities

Freedom of Choice

Most Medicaid recipients may choose the doctor or clinic they wish to use to receive services. However, the doctor or clinic must be willing to accept Medicaid's payment.

Civil Rights

Participating providers of services in the Medicaid program must comply with the requirements of certain laws. Under the terms of those laws, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, age, gender, color, national origin, or disability. This includes distinction made on the basis of race or disability with respect to waiting rooms, hours for appointments, or order of seeing patients.

Eligibility Reporting Requirements

When a person accepts a Medicaid card, that person (or his or her representative) must report all changes in either income or resources that could affect his or her eligibility. These changes should be reported to the local Medicaid office that serves your county of residence by phone, in writing by mail, or by visiting the regional office in person. All changes must be reported within 10 days after the change happens (or within 10 days after the beneficiary realizes the change has taken place). Failure to report a change may result in the beneficiary receiving the wrong Medicaid benefits.

Report Third-Party Insurance

Persons who apply for, as well as those who already have Medicaid, must report all types of health insurance or third-party coverage policies they may have. "Third party" includes any type of policy which would pay for medical services such as health insurance, workers' compensation, employer liability, indemnity policies, major medical policies, CHAMPUS, and lawsuit settlements. In order to be eligible for Medicaid, state law requires as a condition of eligibility that a Medicaid beneficiary sign over all third-party rights to medical payments from any source to the Division of Medicaid. Medicaid beneficiaries should identify all third-party policies in addition to Medicaid coverage whenever any medical service is provided. This will allow the provider to file and obtain those benefits before filing the Medicaid claim.

You may be held responsible for account balance if primary insurance is not provided.

Child's Name: _____ Date of Birth: _____

Parent Signature: _____ Date: _____