

HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES
PATIENT INFORMATION

Patient's Name _____ Sex Male Female **Date of Birth** _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ Cell Phone _____ E-mail address _____
Driver License # _____ **SS#** _____ Marital Status Single Married Widowed
Occupation _____ Employer's Name _____ Work Phone _____
Spouse's Name _____ Employer's Name _____ Work Phone _____
In case of emergency, notify _____ Relation to Patient _____ Phone _____
Your Pharmacy _____ Phone _____ Referred by _____

Complete the Following if the Patient is a Minor or a College Student

Responsible Party's Name _____ Relationship to Patient _____
Father's Name _____ Home Phone _____ Cell Phone _____
Social Security # _____ **Date of Birth** _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call Yes No
Mother's Name _____ Home Phone _____ Cell Phone _____
Social Security # _____ **Date of Birth** _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call Yes No
Hospital where child was born _____
Other Children (Names and Ages) _____
Is there anyone other than a parent authorized to seek treatment for your child? If so, please list below:
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____

INSURANCE INFORMATION: (Please provide copy of current insurance card)

Insurance Name _____ Policyholder's Name _____ **D.O.B.** _____
Policy Number _____ Group # _____ Group Name _____
Medicare # _____ Medicaid # _____

RELEASE OF INFORMATION:

I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.

ASSIGNMENT OF BENEFITS:

I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.

FINANCIAL POLICY:

I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.

PRIVACY POLICY ACKNOWLEDGEMENT:

I acknowledge that I have read and/or been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have read and agree to the Release of Information, Assignment of Benefits, Financial Policy, and Privacy Policy Acknowledgement paragraphs as stated above.

Patient or Responsible Party Signature DATE _____

Relationship to Patient If Not Parent or Legal Guardian

HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES
FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

FULL PAYMENT OR YOUR INSURANCE CO-PAY, CO-INSURANCE AND/OR DEDUCTIBLES, IF APPLICABLE, IS DUE AT THE TIME OF SERVICE. YOU MAY PAY BY CASH, CHECK, OR FOR YOUR CONVENIENCE, CREDIT CARD. WE ACCEPT VISA, MASTERCARD, AND DISCOVER.

IF YOU ARE UNABLE TO PAY AT THE TIME OF SERVICE, PAYMENT ARRANGEMENTS MUST BE MADE PRIOR TO BEING SEEN.

PATIENTS WITH INSURANCE THAT WE ACCEPT

It is your responsibility to know your insurance benefits. Coverage for services like well care, immunizations, lab, x-ray, etc. vary from one insurance plan to another and you are responsible for payment of services rendered whether or not they are covered by your insurance. The labs that we utilize are Clinical Pathology Laboratory (CPL) and Huntsville Memorial Hospital. If your insurance requires that your lab work be performed elsewhere, you must let us know. You are responsible for deductibles, co-pays, non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. **Payment of co-pays, co-insurance and/or deductibles is required at the time of service.** The remaining balance should be taken care of within one (1) month of notice from your insurance company. If your insurance delays payment over 60 days, we ask that you please begin payment on your outstanding balance which is your responsibility. Any overpayment by you or your insurance carrier will be refunded.

PATIENTS WITH INSURANCE THAT WE DO NOT ACCEPT

Please make payment for your care at each visit. We will provide you with a complete receipt that includes all items necessary for you to submit a claim to your insurance.

PATIENTS WITHOUT INSURANCE (PRIVATE PAY)

Please make payment for your care at each visit.

MEDICARE PATIENTS

Our office will submit your Medicare claim and your secondary insurance. You are responsible for deductibles, co-pays, and any non-covered services.

WORKERS COMPENSATION PATIENTS

We will file your Worker's Compensation claim if it can be verified by your employer and you provide us with the complete billing information. You are ultimately responsible for the balance.

PERSONAL INJURY PATIENTS (MVA OR ACCIDENT)

If you are a personal injury patient, you will be asked to pay for your services at the time of your visit. We will provide you with a complete receipt that includes all the necessary information for you to file your claim with the responsible party, however, the balance is ultimately your responsibility.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

OUTSTANDING BALANCES

Any balances older than 30 days of services rendered may be subject to additional collection fees and/or finance charges of 18% annually (1 ½ % per month) unless previous financial arrangements have been made. We realize that temporary financial problems may, at times, affect timely payment of your account. If such problems do arise, we encourage you to contact our Billing Dept. promptly to make payment arrangements.

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE STATUS

HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES

PEDIATRIC PATIENT HISTORY

Patient Name _____ D.O.B. _____ Date _____

BIRTH HISTORY

Type of Delivery _____ Term _____
Premature at _____ Months _____
Pregnancy Number _____
Hospital Born At _____
Birth Weight _____ Blood Type _____
Circumcision _____
Other _____

FAMILY HISTORY

High Blood Pressure _____ Cancer _____
High Cholesterol _____ Allergies _____
High Triglyceride _____ Asthma _____

NUTRITION HISTORY

Breast _____ Formula _____
Vitamin Supplement _____ Type _____
Soft Foods Added _____

INOCULATION HISTORY

Please provide us with a copy of your child's immunization record Today or at your next visit

DEVELOPMENT HISTORY

ILLNESS HISTORY

General _____
Allergies _____
Chicken Pox _____
Tonsillitis/Pharyngitis _____
Ear Infections _____
Asthma/Bronchitis _____
Hospitalized _____
Serious Injuries _____
Operations _____
Other _____

	AGE	AGE
Held Up Head	_____	First Teeth _____
Smiled	_____	Crept _____
Sat Aided	_____	Stood Alone _____
Stood Aided	_____	Walked _____
Sat Alone	_____	Said Words _____
Reached for Objects	_____	Sentences _____
HABITS: Sleep _____		
	Bed Wetting	_____
	Naps	_____
	Play	_____
	School	_____
	Other	_____