Ringgold Pediatric Clinic
Financial Policy

Insurance:

1. For your protection and for identification purpose, we will now keep a copy of the guardian's driver's license in the patient's chart.
2. As a courtesy to our patients, we file patients' claim with insurance companies. We cannot bill your insurance unless you provide us with all insurance information. If you do not provide us with this information on a timely manner, your insurance may deny payment and you will be held accountable for all charges due.
3. It is your responsibility to provide us with any changes in demographics (address, phone numbers, name change, etc...) so that we can contact you and mail you statements at the correct address. Accounts that are past due after 3 statements are sent to a collection agency.
4. When we verify your insurance information at the time of service and you are shown as not eligible, you are expected to pay the full amount of the charges up front.
5. Copays are expected at time of service. A $15 fee will be added to your charges if we have to send a statement for the copay. It is your responsibility to know what your copay and deductible amounts are. We accept all credit cards as form of payment.
6. Patients with an old balance are required to make a payment on their old balance plus pay their copay.
7. A $20 fee will be added to your charges for any canceled check. We will gladly hold a check for a couple of days upon request.
8. If your insurance requires a Primary Care Provider (PCP) to be selected, and we are not your assigned PCP, it is **YOUR RESPONSIBILTY, NOT OURS,** to call your insurance **on the date of service** at our office to select us as your PCP. Failure to do so may result in denial of payment from your insurance, and you will be accountable for the balance.
9. Make sure to call your insurance **immediately** to add a newborn or other new family member to your insurance coverage. Failure to do so will result in denial of payment.
10. If you have a change in insurance company, it is your responsibility to obtain a statement proving termination of coverage from the old company. Insurance companies assume you still have coverage with the other company and deny payment until the insured proves otherwise.
11. Please help us better serve you by keeping scheduled appointments. We will charge a $20 fee for repeated missed appointments not cancelled 24 hours in advance.
12. Please follow up promptly with your insurance company when they ask you supplemental information. Do not just discard this correspondence, since they will not pay until the information is received, or may never pay if it is received untimely.
13. We will gladly work with you to make a payment plan if you need assistance.

PLEASE UPDATE WITH ANY NEW CHANGES

Patient Name: ____

Address: ____

____

Phone: ____

DOB: ____

Ringgold Pediatric Clinic
Patient Financial Responsibility

I understand that it is my responsibility to provide Ringgold Pediatric Clinic with the proper insurance information needed to file a claim with my insurance company. I also understand that **I will be responsible for all charges incurred from this office visit if my insurance company (Private, Medicaid, Wellcare, Amerigroup, Tenncare) declines payment for non eligibility or exceeding filing time limits.**

MUST BE SIGNED AT EACH VISIT

Date	Parent/ Guardian Authorized Person Print Name	Relationship	Signature

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Child's Last Name _____ First Name _____ Middle Name _____

Date of Birth ____ / ____ / _____ Age _____ Sex of Patient ☐ Male ☐ Female Social Security # _____-_____-_____

School Name _____ City/State _____

Names of brothers or sisters _____

Name of Child's Legal guardian _____ **Relationship to child** _____

LEGAL GUARDIAN INFORMATION (if other than father or mother)

Name _____ Social Security # _____ - _____ - _____

Address _____ Date of Birth _____ / _____ / _____

City/State/Zip _____ Home Phone # _____ - _____ - _____

Employer _____ Portable/Cell # _____ - _____ - _____

Work Phone # _____ - _____ - _____ Ext _____

FATHER'S INFORMATION

Name _____ Social Security # _____ - _____ - _____

Address _____ Date of Birth _____ / _____ / _____

City/State/Zip _____ Home Phone # _____ - _____ - _____

Employer _____ Portable/Cell # _____ - _____ - _____

Work Phone # _____ - _____ - _____ Ext _____

MOTHER'S INFORMATION

Name _____ Mother's Maiden Name _____

Address _____ Social Security # _____ - _____ - _____

City/State/Zip _____ Date of Birth _____ / _____ / _____

Employer _____ Home Phone # _____ - _____ - _____

Work Phone # _____ - _____ - _____ Ext _____ Portable/Cell # _____ - _____ - _____

INSURANCE INFORMATION

Is patient covered by Medicaid or PeachCare? ☐ Yes ☐ No ☐ Not currently, but has applied for Medicaid or PeachCare.

Primary Insurance Company _____ Effective date _____ / _____ / _____

Seconday Insurance Company _____ Effective date _____ / _____ / _____

EMERGENCY CONTACT [Other than parent or guardian]

Name _____ Phone # _____ - _____ - _____ Relationship _____

Name _____ Phone # _____ - _____ - _____ Relationship _____

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS [must read, sign and date]

I authorize the release of any medical information necessary to process my insurance claim (s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand I am financially responsible for all charges not covered by Medicaid.

Signature _____ Date _____ / _____ / _____

AUTHORIZATION TO RELEASE INFORMATION

Identification of Parent/Guardian/Custodian is required

Please print clearly
Parent/Guardian/Custodian _____ Relationship _____

Address _____ Telephone # _____

City/State/Zip _____

Do you have LEGAL CUSTODY of the child/children? YES NO

Patient _____ Date of Birth____/____/____

Patient _____ Date of Birth____/____/____

Patient _____ Date of Birth____/____/____

Patient _____ Date of Birth____/____/____

I authorize the release of medical information from the medical record(s) of the above patients.

FROM: Doctor/Healthcare Facility/other _____

Address: _____

City/State/Zip _____

Telephone #: _____ Fax #: _____

TO: Ringgold Pediatric Clinic
7494 Battlefield Pkwy
Ringgold, GA 30736
(706)935-5437 Fax# (706) 935-3004

I am switching my child to Ringgold Pediatrics for the follow reason(s):

_____

_____

Signed: _____

Relationship _____ Date _____

RINGGOLD PEDIATRIC CLINIC

Patient Consent for Physician to Use or Disclose Health Care Information for Treatment, Payment and Health Care Operations

Patient's name:_____ Date of birth:_____

SSN:_____

I understand that my health information is private and confidential. I understand that Dr. Ho works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Dr. Ho may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

Dr. Ho has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Dr. Ho may update this "Notice of Privacy Practices". If I ask, Dr. Ho will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Dr. Ho to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Dr. Ho does not have to agree to my request. If Dr. Ho does agree to my request, I understand that Dr. Ho would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that Dr. Ho may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by Writing, signing, and dating a letter to Dr. Ho. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

I understand if I cancel this consent, Dr. Ho does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Dr. Ho's "Notice of Privacy Practices."

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Patient Eligibility Screening Record

Vaccines for Children Program

Ringgold Pediatric Clinic, PC participates in the Vaccine for Children Program (VFC). If you meet the requirements of this program, we can provide your child's vaccinations at a reduced fee. In order to determine eligibility we must know if your child has insurance that pays for vaccinations.

Date _____/_____/_____

Child _____
Last Name First M.I.

Date of Birth _____/_____/_____

Parent/Guardian/
Individual of Record _____
Last Name First Name

Provider Ringgold Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger who receive immunization through the VFC program. The parent, guardian or individual of record, or by the healthcare provider may complete the record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

INSURANCE COVERAGE (Check statement that applies)

_____ The child has insurance that pays for vaccinations
_____ The child has insurance, but I do not know if it pays for vaccinations. I will contact my insurance company to find out if it pays for vaccinations.

VFC PROGRAM

The child qualifies for vaccination through the VFC program because he/she (check only one box):

(a) is enrolled in Medicaid ☐

(b) does not have health insurance ☐

(c) is American Indian or Alaskan Native ☐

(d) has health insurance that Does Not pay for vaccines ☐

(e) is enrolled in Peach Care for Kids (VFC for Georgia residents only) ☐

AUTHORIZATON TO OBTAIN TREATMENT

Parent/Guardian

In the event you are not able to bring your child in to the office for treatment, we must have an authorization file stating who is authorized to obtain treatment for your child. Pleas fill out the following, read and sign the authorization.

Patient Name_____ Date of Birth_____

Parents Names_____

Legal guardian/custodian/representative_____

I authorize the following person(s) to obtain treatment (including immunizations) for the patient listed above from **Ringgold Pediatric Clinic, P.C.**

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall remain in effect indefinitely, unless withdrawn by my written request.

_____ _____

Signature Relationship to Patient / Date

AUTHORIZATION TO LEAVE PHONE MESSAGES

DO_____ **DO NOT_____**

I authorize Ringgold Pediatric Clinic to leave a phone message to any number I listed in the patient information form, to remind me of my appointment and share health information.

_____ _____

Signature Date

Risk Assessment Questionnaire

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

Assessment Dates: __/__/__, __/__/__, __/__/__, __/__/__, __/__/__, __/__/__

Lead (ages 6-72 months): Mandatory Questions	**Yes**	**No**	**Unsure**
Does the child live in or regularly visit a house/apartment built before 1950? (This could include a daycare center, home of a baby sitter, or a relative.)			
Does the child live in or regularly visit a house/apartment built before 1978 with recent or ongoing remodeling?			
Does the child have a sibling or a playmate that has, or did have lead poisoning?			

Lead (ages 6-72 months): Optional Questions	**Yes**	**No**	**Unsure**
Does the child live near or visit with someone who lives near a lead smelter, battery recycling plant or other industry that could release lead or has a hobby which uses lead such as welding, construction, or pottery making?			
Does your child frequently come in contact with an adult who works with lead? (Construction, welding, pottery, etc.)			
Have you ever been told that your child has low iron?			
Does your child live in or regularly visit a house (or daycare facility) built before 1960?			
Does your family use pottery ware or lead crystal for cooking, eating, or drinking?			
Has child been seen eating paint chips, crayons, or soil/dirt?			
Is child given any home or folk remedies that may contain lead? (may include moonshine, Azarcon, Greta, Paylooah)			
Does your home's plumbing have lead pipes or cooper piles with lead solder joints?			

Please note: Lead level laboratory test are mandatory at 12 and 24 months.

Tuberculosis (Initiate at one-year)	**Yes**	**No**	**Unsure**
Has child been in close contact with a person with infectious tuberculosis?			
Does child have HIV infection or considered at risk for HIV infection?			
Is child foreign born (especially in Asia, Africa, or Latin America), or a refugee, or an immigrant?			
Is child in contact with the following individuals? HIV infected, homeless, nursing home resident, institutionalized or incarcerated adolescent or adult, illicit drug users, or migrant farm workers?			
Does child have a depressed immune system, either because of disease or treatment of disease?			
Does child live in an established "high risk for tuberculosis" community or area?			

Cholesterol (Initiate at two-years)	**Yes**	**No**	**Unsure**
Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?			
Is there a family history (parents and grandparents) of coronary or peripheral vascular disease below age 55?			
Is there a family history (parents and grandparents) of elevated blood cholesterol?			

Ringgold Pediatric Clinic

PATIENT HISTORY INFORMATION

Perinatal

Date of Birth: _____ Birth Weight: _____

Mothers Name: _____ Age: ____ # of Children: ____

Hospital: _____

Breast Fed: Yes No Formula: _____

C-Section: Yes No Group B Strep: Pos Neg

Household Profile

Parents in Household

Biological Mother:	Yes	No	_____
Biological Father:	Yes	No	_____
Divorced:	Yes	No	_____
Smokers:	Yes	No	_____
Cats:	Yes	No	_____
Dogs:	Yes	No	_____

Hospital/Surgery/Trauma

Date:	Hospital	Doctor	Diagnosis

Family/Patient History

	Patient	Other
Allergy/Asthma		
Diabetes		
Heart Disease		
Lung Disease		
Digestive/Ulcer/Liver		
Kidney/Bladder Disease		
Cancer		
Bleeding/Blood Disease		
Birth Defects		
Seizures		
Mental Retardation		
SIDS		
Other		

Drug Reaction/Allergies

Date	Medication	Reaction	Allergy?

Date	Problem List	Medication	Doctor/Referral

Name: _____ Date of Birth: _____