Van Meter Pediatric Endocrinology, PC
PATIENT INFORMATION FORM

PATIENT INFORMATION Preferred Name______________

Last Name__________________________First_____________________MI__________________

Date of Birth________________________ SS#____

Address_______________________________________City____________________State_______

Zip__________________

How did you hear about us?____

Name of Primary Care Physician?____

RESPONSIBLE PARTY (Person completing and signing paperwork)

Last Name________________________First______________________MI__________________

Relationship to Patient_________________________Home#_____________________________

Work#________________________________Cell#______________________________________

Date of Birth____________________________SS#_______________________________________

Address if different from Patient____

Employer______________________________Address____________________________________

Phone #______________________________Email:______________________________________

INSURANCE INFORMATION

Primary

Ins.______________________Address__________________________Ph#___________________

Policy ID#______________________________Group#____________________ HMO PPO POS

Employer____________________CO-Pay Specialist_______________Deductible___________

Policy Holder: Last Name_____________________First Name__________________________

SS#_____________________________________ Date of Birth____________________Sex M F

Relation to Patient_______Address if different from Patient___________________________

Secondary

Ins.____________________Address________________________Ph#_________________

Policy ID#___________________________Group#__________________ HMO PPO POS

Employer__________________CO-Pay Specialist_____________Deductible__________

Policy Holder: Last Name___________________First Name________________________

SS#_________________________________ Date of Birth__________________Sex M F

Relation to Patient______Address if different from Patient_________________________

EMERGENCY CONTACT

Name_______________________________________Phone_________________________

Relationship to Patient____

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I,______________________, have received a copy of Van Meter Pediatric Endocrinology, P.C.'s Notice of Privacy Practices.

Signature of Responsible Party:____Date:___________________________

ASSIGNMENT OF BENEFITS AND RIGHT OF RECOVERY

I request payment of authorized insurance benefits be paid to Van Meter Pediatric Endocrinology, P.C. and authorize release of medical information as needed to determine payable benefits for services rendered. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on me behalf and I herby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Van Meter Pediatric Endocrinology, P.C. by any insurance policy, self-insurance program or other benefit plan. This authority shall remain in effect until revoked by me in writing. A photocopy of this authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be as effective and valid as the original

Signature of Responsible Party:____Date:____________________

MEDICAL TREATMENT PERMIT

Permission is herby given for medical diagnosis and/or treatment as may be deemed advisable or necessary by the medical staff of Van Meter Pediatric Endocrinology, P.C.

Signature of Responsible Party:____Date:____________________

Practice Financial Policy

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Co-payments for office services are required at the time services are rendered.

- As a courtesy, we will process and file your insurance claims for services at no cost to you.

- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.

- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.

- In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

- **Check Acceptance Policy**
  In the event that your check is returned unpaid for insufficient or uncollected funds:

  - Returned checks are subject to a handling fee of $35.00.
  - We may re-present your check electronically or by paper-draft.
  - A service charge for the maximum amount allowed by state law will be assessed, along with any other allowable state fees.
  - Your check will not be provided to you with your bank statement, but a copy can be retrieved by contacting your financial institution.
  - Signature of your check constitutes acceptance of these terms.

You must realize that:

- Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts.

- If you have a balance due with our office you may be contacted by mail, email, fax, telephone and your cell phone in order for our office to collect the balance due. By providing our office with your contact information you are consenting to the above methods of contact.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING

Signature:_______________________________________ Date:__________________
(Patient and/or Responsible Party)

Financial Policy for "No Show" of Visits

We are a small office committed to devoting ample time to you and your child. When we make an appointment for your child, that time is set aside for your child only. Therefore, we will be instituting a "No Show" fee of $70.00 for all follow-up appointments that are missed and not rescheduled or cancelled. **This fee is $ 70.00** Please give our office at least 24 hours notice if you cannot keep an appointment. Thank you for your cooperation.

Signature ______________________ Date ______________

Referral Policy for Visits

Please note that if your child's insurance policy requires a referral to a specialists' office, such as ours, that it is your responsibility as guardian to obtain the referral or authorization before your child's appointment. If there is no valid referral or authorization on file for your child at the time of their scheduled appointment, this will cause a wait time and may result in having to reschedule your child's appointment.

Signature ______________________ Date ______________

1800 Howell Mill Rd - Suite 475
Atlanta, Georgia 30318
678-961-2100
www.PediatricEndo.com

Attention Parents, Office Policies:

Prescriptions/Lab orders/Paperwork requests:
Please keep in mind that when you are calling for prescription refills or lab orders, we may be experiencing high call volumes. This can result in a turnaround time of up to ***24 hours***.

Therefore, please allow 24 hours before you call back to check the status of your request. Please also keep in mind that you can check on the status of refills with your pharmacy directly. We also suggest that you do not wait until your child is out of medication before you call for a refill.

For paperwork (such as diabetic careplans and FMLA), please understand that the beginning of the school year is a very busy time for us. As such, these kinds of requests may take up to one week for fulfillment.

Appointments:
Please be aware it is office policy that we ***alternate morning and afternoon appointments.*** We find this to be the fairest policy as most children are school age, and most parents work. **Please also note: if you are more than 15 minutes late for your appointment you may be asked to reschedule.**

__________________________________ ________________
SIGNATURE DATE

Primary Insurance Verification Form

If your child is covered by more than one commercial insurance plan, you MUST relay this information to our front desk personnel upon checking in.

If you willingly withhold this information you are **committing insurance fraud**.

It is in your best interest to provide us with all insurance coverage's effective for your child on the date they are seen, and update us with any changes that take place with your insurance.

Our office policy on this issue is very simple: the insurance information you provide to us is the information we will use to obtain payment for services rendered. If you do not provide us with the correct insurance information, YOU, the parent/guardian of the child to whom services were provided, will become responsible to pay for all denied and recouped fees, due to inaccurate insurance information presented to our practice.

Please read the above notice carefully before **signing** in agreement below.

Does your child have additional insurance coverage; ☐Yes ☐ No
If Yes, please list below all insurance information.

***SIGNATURE*____________________________________*DATE*____________________**

Insurance Coverage:

Patients Name/Date of Birth ____

I confirm that the above child is covered under the following insurance companies only.

Insurance Company ____

Effective Date ____

ID Number ____

Additional Insurance Company ____

Effective Date ____

ID Number ____