ROXBORO

# MedPeds

## PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐Female

Address: _____
(Street/mailing) (City) (State) (Zip)

Patient's Birth Date: ____/____/_____ Patient's Social Security Number: ____/____/_____ ___

Contact Info: Home:_____ Work:_____ Ext:_____

Cell: _____ Email: _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

Ethnicity: Hispanic origin? ☐ Yes ☐ No ☐ Prefer not to answer
Preferred Language: _____

Employed ☐ Yes ☐ No If yes, Employer: _____

Address: _____
(Street/mailing) (City) (State) (Zip)

Preferred Method of Contact: ☐ Phone ☐ Mail ☐ email

Pharmacy Name _____ City/State _____

## PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT (if different from patient) **REQUIRED**

Name: _____ Relationship to Patient: ☐ Mother ☐ Father

☐Guardian ☐Other:_____

Address: _____
(Street/mailing) (City) (State) (Zip)

Responsible's Birth Date: ____/____/_____ Responsible's Social Security Number: ____/____/_____

Contact Info: Home:_____ Work:_____ Ext:_____

Cell: _____ Email: _____

_____

Responsible Employed: Yes No If yes, Employer_____

Address: _____
(Street/mailing) (City) (State) (Zip)

Patient/Guardian Signature _____ Date _____

# ROXBORO MEDPEDS

## Authorization of Use and Disclosure of Protected Health Information

**Information covered by this authorization includes:** All personal health information

**Purposes of Disclosure:** To provide medical care

**Persons Authorized to Use or Disclose Information:** Roxboro Internal Medicine & Pediatrics, PA

**Right to Terminate or Revoke Authorization**
You may revoke or terminate this by submitting a written revocation to Roxboro Internal Medicine & Pediatrics, PA You should contact the Privacy Officer to terminate this authorization.

**Potential for Re-disclosure**
Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

**Rights of the Individual**
You may inspect or copy information that is used or disclosed under this authorization. You may refuse to sign this authorization.

**Persons to Whom Information May Be Disclosed (other doctors, spouse, children, sister, brother, etc.):**
(We cannot release personal health information to anyone whose name is not listed below.)

Name of persons/organizations:

_____

_____

_____

_____

**Effect of Refusing Authorization**
If you refuse to sign this authorization, we will not deny you any treatment, except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____
Treatment conditioned on authorization

**Acknowledgment of Receipt of Notice of Privacy Practices**
Your signature below indicates you have received a copy of the Notice of Privacy Practices for Roxboro Internal Medicine & Pediatrics, PA Roxboro Internal Medicine & Pediatrics, PA, reserves the right to modify the privacy practices outlined in the notice.

**Signature**

_____ _____
Name of Patient (Print or Type) Signature of Patient

_____ _____
Signature of Patient Representative and relationship Date

ROXBORO

# MedPeds

## PRESCRIPTION HISTORY PATIENT CONSENT FORM

Date: _____

Patient: _____ Date of Birth: _____

To provide you with the best medical care, it is important that Roxboro MedPeds has access to your complete prescription history, which includes medications prescribed by providers outside of Roxboro MedPeds. Please sign below to help us make the best, most informed medical choices for you and your family.

I hereby give permission to Roxboro Internal Medicine & Pediatrics, P.A., to obtain and review my external prescription history.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Date

ROXBORO

# MedPeds

## PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Roxboro Internal Medicine & Pediatrics' Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

Print Patient Name _____ Date _____

Signature of Patient or Representative _____

Relationship of Representative to Patient _____

Please describe the Representative's authority to act on behalf of Patient:

_____

_____

FOR ROXBORO MEDPEDS USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

_____

# Roxboro MedPeds
# Patient Financial Policy

## NOTE: Document continues on reverse

It is the policy of this office to help keep your health care costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- √ Always bring your current health insurance card to the office.
- √ Please notify us at time of check-in of any changes in insurance, address, telephone or family status.
- √ Please pay your co-pay or deductible at the time of service; or if you do not have insurance, please come prepared to pay for your visit in full. We accept cash, checks and credit cards.
- √ If you are unable to present a valid member identification card from your carrier at your visit, we will expect payment in full until you are able to verify your insurance coverage.
- √ You should receive a bill for any patient responsibility within 30 days; and/or an explanation of benefits from your carrier. If you do not, please contact the billing office at 336.598.0002.

**Statements:** If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment or credits applied to your account during the month.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

**Payment Options if you have Insurance:** We are required by our insurance contracts to collect all co-pays, at the time of service. Again, we accept cash, checks or credit cards to assist you in paying for co-pays, or coinsurance and deductible amounts.

**Payment Options if you have No Insurance**: Your choice is to pay by cash, check, or credit card on the day that treatment is given. If payment is made at time of service, Roxboro Internal Medicine and Pediatrics, PA will reduce cost of service by ten percent (10%).

If payment cannot be made in full at the time of service, a budget agreement may be made to have service paid within 90 days with the 1st payment payable the day the service is rendered. Such agreements are at the sole discretion of Roxboro Internal Medicine and Pediatrics, PA.

**Insurance:** It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.

**Divorce:** In case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Insurance Release:** This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for service rendered if any of the following conditions apply:

- Δ I may have a pre-existing condition or other diagnosis that may not be covered by my plan.
- Δ Provider not participating in my health plan.
- Δ Unmet deductible under my health plan contract.
- Δ Services may not be covered under my health plan.
- Δ Well child check-up, immunizations, as well as other routine services, may not be covered by some insurance plans. Please check with your insurance carrier if you're not sure if routine services are covered.

**Past Due Accounts**: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers fees that we incur, plus all court costs. If we need to send the balance of an account to collection because of non-payment of the account, the physicians of Roxboro Internal Medicine and Pediatrics, PA will no longer be able to provide care. This will also apply to any immediate family members that are patients of Roxboro Internal Medicine and Pediatrics, PA. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider.

All accounts sent to the collection agency will incur a $50.00 fee and be reported to the Credit Bureau.

**Returned Checks:** There is a fee (currently $25.00) for any checks returned by the bank. This amount may change and is in the sole discretion of Roxboro Internal Medicine and Pediatrics, PA.

**Missed Appointment Fee:** When a patient does not show on time for an appointment a $25.00 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with 4 missed appointments may be asked to transfer their records to another doctor.

**Waiver of Confidentiality:** You understand if we submit your account to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Transfer of Records:** You will need to complete the authorization to release records form, which can be obtained from our office. This form needs to be completed in its entirety and payment for the copy of medical records as indicated on the release form in order for us to process the request. All balances should be paid before records are transferred.

**Effective Dates:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

**Authorization for Claim Processing:** I authorize the release of all medical records to my health insurance company, if applicable. I authorize transmission of medical information to be faxed. I authorize any health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan.

I further authorize and request that insurance payments be made directly to Roxboro Internal Medicine and Pediatrics, PA should they elect to receive such payments.

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorney for collections, the undersigned shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the physician care of Roxboro Internal Medicine and Pediatrics, PA.

I have read this Patient Financial Policy as outlined, and understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian.

This is an agreement between Roxboro Internal Medicine and Pediatrics, PA, as creditor, the Patient/Guardian, or Parent as debtor, named on this form.

In this agreement, the words "you," "your," and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Roxboro Internal Medicine and Pediatrics, PA.

By executing this agreement, you are agreeing to pay for all services that are received.

_____ / _____

Patient/Guardian Signature Date

_____

Patient/Guardian Name (PRINTED)