Tuscaloosa Pediatrics, P.C.

___ Denise Brown, M.D.
___ Allison Cunningham, M.D.
___ Megan McGiffert, M.D.

Select 1st & 2nd Choice Physician

___ Michelle Parchman, M.D.
___ Kaila Sullivan, CRNP
___ Julie Vaughn, M.D.

Account #: _____ Date: _____

Name you prefer we call your child: _____ Social Security #: _____

Last: _____ First: _____ Middle Name: _____

Date of Birth: _____ Sex: Male_____ Female_____

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling: _____ DOB_____ Sibling: _____ DOB_____

Sibling: _____ DOB_____ Sibling: _____ DOB_____

Ethnic Group: Hispanic Non Hispanic **Race:** Asian Black White Other_____

Language: Arabic English German Korean Spanish Other_____

Select one for Appointment Reminders: Text#: _____ **Phone#:** _____

Email: _____

Mother Stepmother Guardian

Name: _____
Cell Number: (_____)_____
Work Number: (_____)_____
Home Number: (_____)_____
E-mail Address: _____
Employer: _____
Occupation: _____
Social Security #: _____
Driver License/St.: _____
Marital Status: _____

Father Stepfather Guardian

Name: _____
Cell Number: (_____)_____
Work Number: (_____)_____
Home Number:(_____)_____
E-mail Address: _____
Employer: _____
Occupation: _____
Social Security #: _____
Driver License/St: _____
Marital Status: _____

Emergency Contact (other than parent): _____ Phone#: _____

Patient's cell phone number if age 14 years or older. (State of AL Age of Consent is 14)_____

Primary Insurance

Insurance Co: _____
Policy Holder: _____
Contract/ID#: _____
Group #: _____
Effective Date: _____
Relation to Child: _____
Policy Holder Date of Birth: _____

Secondary Insurance

Insurance Co: _____
Policy Holder: _____
Contract/ID#: _____
Group #: _____
Effective Date: _____
Relation to Child: _____
Policy Holder Date of Birth: _____

Does your insurance require a Primary Care Doctor or any type of Physician Referral?_____
Does your insurance require you to use a specific lab or x-ray facility? ___ If so, which one?_____

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, Alabama 35406
Phone 205-333-8222
Fax 205-333-8233

Consent to Receive Cell Phone Calls or Text Messages

As a service to our clients we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone you consent to receive such calls or text messages on your cell phone. If you do not want to be contacted in the above manner, please do not provide your cell phone number when you complete the Demographics information.

Parent/Patient Signature: _____

Date: _____

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, AL 35406

HIPAA Authorization Statement

(Please complete the following so we may contact you properly & securely)

Please list the family members or to the persons, if any, whom we may inform about your child's general medical condition and diagnosis (including treatment, payment, and healthcare operations).

Name _____

Phone # _____

Name_____

Phone #_____

Please list the family member or significant others, if any, whom we may inform about you r child's medical condition ONLY IN CASE OF EMERGENCY.

Name _____

Phone # _____

Name_____

Phone #_____

If you would like your billing statement and/or correspondence from our office to be sent to an address other than you home, please list below.

Name _____

Address_____

Please list the telephone number(s) you would like to be contacted at for appointment, lab, and x-ray results or other health care information if other than your home telephone number. (Please be aware that a cell phone is not a secure and private line).

Telephone #_____ Telephone #_____

Can confidential messages be left on your telephone answering machine? YES / NO

_____

Patients Name (Please Print)

_____

Signature (Parent/Guardian if under 18 years of age)

Tuscaloosa Pediatrics Financial and Office Policies

Please be aware if you are a new patient and fail to show up for your 1st appointment without giving a 24 hour notice, you may be asked to find another medical office or physician for medical care.

Please be aware our office does not accept all insurances. You may be asked to transfer out of the practice if you change to an insurance we do not accept, change to a plan we are no longer participating with, or our enrollment for your insurance is full at that time.

All professional services rendered by Tuscaloosa Pediatrics, P.C. are charged to the patient. We will gladly file your insurance for you. However, the parent or guardian is responsible for all fees that are not covered by the insurance.

We are required to report visits outside of normal business hours to your insurance provider. Any appointment scheduled before 8am, after 5pm, and on Saturday or Sunday will incur an additional fee. This fee will be billed to your insurance provider, but may be applied to your copay, coinsurance, or annual deductible.

Payment is due at time services are rendered (such as co-pays, deductibles and non covered services) regardless of who brings the patient in for his/her visit. There will be a $10.00 administrative fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, MasterCard, American Express and Discover.

No well visits or immunizations will be given if you have an outstanding account balance.

It is the patient's responsibility to know your insurance benefits and whether the physicians in this practice are preferred providers. Some insurance companies require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours if you are seeing or have seen another physician. Don't assume that referrals are done if you don't speak to someone in our insurance office, even if our physicians or nursing staff refer you.

We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance, for a life-threatening emergency or we instruct you to go because we are unable to schedule an appointment here in a timely manner.

Most insurance companies allow 30-45 days for you to add your newborn to your insurance policy. We require you to pay for the visit in full for the 2 month check-up if we cannot verify your baby's enrollment before the visit.

We must have a release signed by a parent or guardian on file to release medical records. We request your account be paid in full in order to release your medical records if you are transferring your child/children to another physician. Accounts that are not paid in full or arrangements made to do so will be treated as a bad debt and will be forwarded to a collection agency.

There is a fee and a 72 hour waiting period on all medical forms, blue cards not associated with a check-up and medical record copying. Please check with the office staff in advance on the cost for each request.

There is a $10.00 fee for after hours telephone calls. Please read and follow our Telephone Policy to avoid unnecessary costs.

There will be a $40.00 No Show/Cancellation fee for failure to cancel your Well Check-up appointment 24 hours prior to the scheduled appointment time and 4 hours prior to sick or recheck appointment time. You could be asked to find another physician for repeat offences.

There is a $25.00 fee on all returned checks.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Tuscaloosa Pediatrics, P.C. has provided my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand the collection agency charges Tuscaloosa Pediatrics a 33 1/3% fee in an effort to collect outstanding balances. This fee will be added to my bill and become my responsibility. I also understand there will be a $10.00 fee added to my bill for any notification sent to me by certified mail.

I hereby authorize Drs. Brown, Cunningham, McGiffert, Parchman, Vaughn and Kaila Sullivan, CRNP to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physicians all payments for the medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Communications Regarding My Account
Until my account is finally settled, I give my direct consent to receive communications regarding my account from any servicers and any collectors of my account, through various means such as 1) any cell or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Patient Name	Patient Date of Birth	
Signature	Relationship	Date

UPDATED: 5/4/2020

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, AL 35406

Receipt of Privacy Practices Written Acknowledgement Form

I, _____ as parent or legal guardian of

_____ have received a copy of the Notice of Privacy
(Name of Child)

Practices Form from Tuscaloosa Pediatrics, P.C.

Signature of Parent or Guardian: _____ Date: _____