Tuscaloosa Pediatrics, P.C.

Select 1st & 2nd Choice Physician

___ Denise Brown, M.D.
___ Allison Cunningham, M.D.
___ Joy Dean, M.D.
___ Megan McGiffert, M.D.
___ Michelle Parchman, M.D.
___ Kaila Sullivan, CRNP
___ Julie Vaughn, M.D.

Account #: ____________________ Date: ____________________

Name you prefer we call your child:________________________

Last:______________________ First:________________ Middle Name: ________________

Date of Birth: ____________________ Sex: Male_______ Female_______

Home Address:____

City:______________________ State:________________ Zip:____________________

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

Language: Arabic English German Korean Spanish Other____________________

Mother Stepmother Guardian

Name:______________________________

Cell Number: (_____)____________________

Work Number: (_____)____________________

E-mail Address:________________________

Employer:______________________________

Occupation:____________________________

Marital Status:_________________________

Father Stepfather Guardian

Name:______________________________

Cell Number: (_____)____________________

Work Number: (_____)____________________

E-mail Address:________________________

Employer:______________________________

Occupation:____________________________

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 Financial and Office Policies

** PLEASE INITIAL ALL BELOW THAT YOU ACKNOWLEDGE AND AGREE **

______ 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 $15.00 administrative fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, and MasterCard.

______ We feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative health care at the ages listed below. We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our children. We understand there are some insurance policies that do not cover yearly check-ups, but do not feel this is a reason for your child not to have them. Failure to do so may result in being discharged from the practice.

- 3-5 days of life
- 2 weeks of age
- 1 month of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15 months of age
- 18 months of age
- 24months of age
- 30 months of age
- 3-18 years of age - yearly

______ If your child is not current on routine check-ups, any refill on chronic medications and/or any routine immunizations may be denied until your child is current on routine check-ups.

______ 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.

Tuscaloosa Pediatrics Financial and Office Policies

______ 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 $15.00 fee for after hours telephone calls. Please read and follow our Telephone Policy to avoid unnecessary costs.

_____ Excluding refills on chronic medications, any prescription not associated with an office visit with one of our providers may be subject to a $15.00 fee.

_____ If you do not cancel your appointment 24 hours prior to the scheduled appointment time, you will be charged a No Show/Failure to Cancel fee. Any office visit that is scheduled with a Physician will incur a $40.00 No Show/Failure to Cancel fee. Any visit scheduled with a nurse will incur a $10.00 No Show/Failure to Cancel fee. Repeat offences could result in being discharged from the practice.

______ If you have not arrived to your appointment within 15minutes of your scheduled appointment time, we will assume you are not coming. In such case, you will be charged the missed appointment fee.

______ 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 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/NAMES -- PLEASE LIST EACH FAMILY MEMBER THAT IS A PATIENT HERE

Signature of Responsible Party	Relationship	Date

February 2023

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 any family members or persons (other than parents), 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 #______________________________

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 voicemail? YES / NO

Can confidential health information be sent via text? YES / NO
(This method of communication is not secure and you are electing to communicate via unsecure text)

____
Patients Name (Please Print)

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

TUSCALOOSA PEDIATRICS

PERMISSION TO ACCESS PRESCRIPTION HISTORY

I, ____, whose signature appears below, authorize Tuscaloosa Pediatrics PC providers and staff to view the prescription history via the Retail Prescription Hub service for the patient listed below.

______________________________________ ______________________

Patient Name (Please Print) Patient Date of Birth

By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

______, I understand that the prescription history is from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers and may be viewable by my providers and staff here, and it may include prescriptions back in time for the last 2 years.

My signature certifies that I have read and understand the above and that I authorize the access.

______________________________________ ______________________ ______________

Signature of Parent/Guardian Relationship to Patient Date