CROWLEY CHILD & ADOLESCENT CLINIC PATIENT REGISTRATION

PATIENT NAME_____ BIRTHDATE_____ ❑ MALE ❑ FEMALE

MOTHER'S NAME:_____ MOTHER'S DATE OF BIRTH_____
LAST NAME FIRST

MOTHER'S SOCIAL SECURITY NUMBER:_____MOTHER'S MAIDEN NAME:_____

MOTHER'S EMPLOYER:_____PHONE # OF EMPLOYER:_____

FATHER'S NAME:_____ FATHER'S DATE OF BIRTH_____
LAST NAME FIRST

FATHER'S SOCIAL SECURITY NUMBER:_____FATHER'S OCCUPATION:_____

FATHER'S EMPLOYER:_____PHONE # OF EMPLOYER_____

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STREET ADDRESS OF PARENT/CUSTODIAN:_____
STREET ADDRESS CITY/ZIP/STATE

HOME PH:( )_____PAGER/CELL PH: ( )_____EMAIL ADDRESS:_____

CUSTODIAN'S NAME:_____
(IF CHILDREN NOT LIVING WITH PARENT) LAST NAME FIRST MIDDLE

EMERGENCY CONTACT (OTHER THAN PARENT)

NAME RELATIONSHIP PHONE NUMBER

LIST ADDITIONAL CHILDREN:

1. _____ MALE OR FEMALE
LAST NAME FIRST MIDDLE DATE OF BIRTH CIRCLE

2._____ MALE OR FEMALE
LAST NAME FIRST MIDDLE DATE OF BIRTH CIRCLE

3._____ MALE OR FEMALE
LAST NAME FIRST MIDDLE DATE OF BIRTH CIRCLE

4._____ MALE OR FEMALE
LAST NAME FIRST MIDDLE DATE OF BIRTH CIRCLE

NAME OF INSURANCE COMPANY:_____ NAME OF PRIMARY INSURANCE HOLDER_____

ID #:_____GROUP #:_____EFF. DATE:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? NAME OF INSURANCE CO:_____
ID# _____ INS. CO. PHONE NUMBER _____

NAME OF POLICYHOLDER: _____

I hereby authorize payment of insurance benefits directly to Crowley Child & Adolescent Clinic. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted provider of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred. I authorize the performance of whatever procedures necessary in executing the treatment of the above name patient (s).

_____ _____
Signature of Parent/Guardian Date

Financial Policy Acknowledgment

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

Crowley Child & Adolescent Clinic has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with *your* insurance company. Any financial portion that is the "member's responsibility" such as a co-pay, deductible or a non-covered percentage will be collected **at the time of service** _____(initial) . If, for any reason, it is not collected at the time of service, a billing fee will be added to your outstanding balance for each statement that is mailed_____(initial). Remember, your insurance coverage is a contract between you and your insurance company. Crowley Child & Adolescent Clinic is not responsible for services denied by your insurance company _____(initial).

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We still estimate co-payments to the best of our ability. Since the co-pays are estimates only, we will bill you for any balance.

HMO INSURANCE PLANS: All co-pays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

NON-CONTRACTED INSURANCE PLANS: If we are not contracted with your insurance company, you will be asked to pay in full at the time of service. We can supply you with a billing copy to attach to a claim form (should be supplied by your insurance broker or Human Resources department) to send to your insurance company to request that payment be sent to you.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you for any balance.

MEDICAID: We accept the Medical Card and all Bayou Health Plans

DIVORCE DECREE: We are NOT a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, Mastercard, and personal checks (with photo id only). Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement will be assessed a $5 rebilling fee. If you experience circumstances beyond your control, please call our office and we will be happy to make payment arrangements. All balances reaching 120 days may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $15 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel with a minimum of one hours notice in order for another child to be scheduled. If you do not cancel by the deadline, a $30 missed appointment fee may be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment.

I authorize medical care and accept the financial responsibility for my children, my step children, and/or the child(ren) that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical information necessary to process any claims.

I have read and fully understand the financial policies of Crowley Child & Adolescent Clinic, and agree to the terms. I also understand that the I have read and fully understand the financial policies of Crowley Child & Adolescent Clinic, and agree to the terms. I also Terms of these financial policies may be amended by the Practice at any time without prior notification.

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_____ _____

Parent/Guardian/Personal Representative Date

Authorization For Medical Treatment of Minors

I,_____, parent or legal guardian of:

_____		_____	
Child's Full Name	Date of Birth	Child's Full Name	Date of Birth
_____		_____	
Child's Full Name	Date of Birth	Child's Full Name	Date of Birth
_____		_____	
Child's Full Name	Date of Birth	Child's Full Name	Date of Birth

Do hereby authorize the following individuals (must be over the age of 18) to schedule appointments and/or accompany my children to medical appointments. Please list anyone other than the child(ren)s' biological mother or biological father who may be accompanying the child(ren) to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc… I understand that only my child (ren)'s biological mother and father and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen age 16 and above, in my absence. Authorized individuals include (please print name and relationship):

_____ _____

_____ _____

_____ _____

Please inform the above listed individuals to bring photo identification to appointments
Unlisted individuals may obtain treatment for your child(ren) in the case of an emergency. In that case, an attempt to contact you by phone will be made. This authorization will remain in effect until those designated above have their consent revoked in writing.

I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Crowley Child & Adolescent Clinic of any changes in my health status, my child(ren)'s health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

_____ _____
Signature Date

Privacy Statement Acknowledgment

I acknowledge Crowley Child & Adolescent Clinic +has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If I desire, a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy. (See date on posted copies)

_____ _____
Signature of Parent/Guardian/Personal Representative **Printed** Name of Parent/Guardian/Personal Representative

Date:_____

Authorization to Leave Messages on Voice Mail/Machines

I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

Yes, please leave me a message_____ Date_____

No, don't leave any specific message_____ Date_____

Acknowledgement of "Abuse Free Zone"

At Crowley Child & Adolescent Clinic we appreciate and respect our staff. If is our belief that our staff should have a work environment free from verbal and physical abuse. We expect you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your discharge from the practice.

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

_____ _____
Signature Date

FOR FAMILIES NEW TO OUR PRACTICE

How did you find out about our office/doctors? Name of Friend/Relative_____

Hospital_____ Yellow Pages_____ Internet search_____ Other_____