

Cornerstone Pediatrics
NEW PATIENT INFORMATION

• Patient Information:

Patient's Name: (First) _____ (Middle) _____ (Last) _____

DOB: ____/____/____, Social Security No. ____-____-____ Gender: () Male () Female

ADDRESS WHERE THE PATIENT RESIDES:

Street _____ City _____ ST _____ ZIP _____

Telephone number where you prefer we contact you regarding the patient: (_____) _____ -- _____

• Guarantor Information: *(The person who brings the child in is financially responsible for this account.)*

Name: (First) _____ (Middle) _____ (Last) _____

DOB ____/____/____, Social Security No. ____-____-____ or FLDL # _____

Home address if different from patient's: _____ City _____ ST _____ ZIP _____

Home Tel. No. (_____) _____ - _____, Cell: (_____) _____ - _____ Relation to Patient: _____

• Other Parent or Legal Guardian Information:

Name: _____ Relation to Patient: _____

Address if different from patient's. _____

DOB ____/____/____, SS# ____-____-____, Tel. #(_____) _____ - _____

If Legal Guardian, under what circumstances have you been assigned guardianship of this patient?

() State Assigned Foster Parent () Adoption () Temporary Custody During Visitation () Other _____

• Family Information:

List only any other siblings or family members that attend Cornerstone Pediatrics, that should be linked to the Guarantor named above.

1. Name _____ Date of Birth: ____/____/____

2. Name _____ Date of Birth: ____/____/____

3. Name _____ Date of Birth: ____/____/____

4. Name _____ Date of Birth: ____/____/____

Print name of person completing patient's information: _____ Relation to Patient: _____

Your telephone # (_____) _____ - _____ Signature: _____ Today's Date: ____/____/____

Cornerstone Pediatrics

AGREEMENT FOR PAYMENT OF SERVICES

Cornerstone Pediatrics is a fee for service practice. Payment for services rendered is requested on the date of service, unless verifiable, active insurance benefits can be obtained. Submitting claims for our patients is a courtesy we offer to patients, but should not be considered a guarantee of payment by your plan. If at any time after submission, the insurance provider named below denies a claim the charges are considered unpaid and due in full by the named responsible party.

- Co-pays and any deductibles are due at the time service is rendered.
- Cornerstone Pediatrics does not submit claims retroactively.
- The person who procures treatment for the child and brings him in is financially responsible for this account.
- Any payments due to this practice for services rendered are assigned to Cornerstone Pediatrics. If you receive payment on a claim for services provided by Cornerstone, your debt remains unpaid, and may cause termination of services by providers.
- It is the parent/guardian's responsibility to assure that your medical insurance covers services at this Practice.
- Guarantors should facilitate the claims process by maintaining data with the insurance company updated, and submitting any and all documents requested by your plan for processing of claims expeditiously.
- Unpaid balances older than 60 days, are due in full at the time of the next visit.
- Accounts remaining unpaid for more than 90 days are automatically forwarded to a collection agency.
- Cornerstone Pediatrics, does file liens against personal property for unpaid charges due the Practice.
- A \$30.00 NSF fee is charged on all returned checks.

Medical Insurance Information: *(Please check all that apply and include the policyholder's name and policy number)*

() Self Pay Account (No commercial medical insurance I am paying with Cash, Check or Credit Card)

() Cornerstone Pediatrics Service Plan Purchased.

() Florida Healthy Kids through Blue Cross/Blue Shield – Policy# _____

() Other Commercial Insurance as described below:

Insurance Co. Name: _____ Policy# _____ Group# _____

Policy Holder/Subscriber's Name as on medical insurance policy: _____ DOB ____-____-____

Policy Holder's Employer: _____, Employer Telephone # (____) _____-_____

Policy Holder/Subscriber's S.S.# _____ - _____ - _____ Relation to Patient: _____

✓ *Please attach the medical insurance card to this sheet for our records.*

The undersigned parent/ legal guardian/guarantor hereby authorizes Cornerstone Pediatrics and/or any provider with this practice To apply for health insurance benefits for covered services rendered to the aforementioned patient. I acknowledge and agree that all insurance payments are directly assigned to the provider, and that should I receive an insurance payment for services due this practice, I will pay the charges due. I acknowledge the information supplied in this form is true to the best of my knowledge, and I understand that supplying false information that hinders procurement of funds for payment of services rendered, or that impedes the ability of medical service(s) and/or diagnosis to be appropriately given for the betterment of the patient, may be used against me should legal proceedings be sought.

Print Patient's Name: _____ DOB ____/____/____

Print name of person completing this form: _____ Today's Date: ____/____/____

Your Signature: _____ Relation to Patient: _____

Cornerstone Pediatrics

Medical Consent and Record of Disclosures

❖ *Consent for Treatment:*

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am submitting the patient under the care and supervision of the attending physician. I understand that my involvement in the betterment of the patient is directly related to following physician orders, filling of medication(s) and or diagnostics prescribed, and maintaining follow-up appointments.

❖ *Medicare and Medicaid Consent to Release Information:*

I certify that the information given by me in applying for payment under the Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about the patient, to release to the Social Security Administration or its intermediary carriers, any information needed for this related Medicaid claim.

❖ *Release of Information:*

I hereby grant Cornerstone Pediatrics consent to use and disclose the patient's protected health information for the sole purpose of treatment and healthcare operations and to procure payment. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices before you sign this consent, and a right to request restrictions on the use and disclosure of the patient's record, by this practice. We are however, not required by law to grant your request. If such request is granted and acknowledged in agreement, we are bound by our agreement. You also, have the right to revoke this consent in writing, except to the extent to which we have already used or previously disclosed the information.

In general HIPAA Privacy Rule gives individuals the right to request restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means.

I wish to be notified on behalf of the patient in the following manner. *(Check all that apply)*

Home Telephone:

- O.K. to leave message with detailed information
- Prefer that callers leave a call-back number only.

Work Telephone:

- O.K. to leave message with detailed information
- Prefer that callers leave a call-back number only.

Written Communication: (Statements automatically get mailed to patients place of residence.)

- O.K. to mail to Guarantor, Legal Guardian, other Parent not living with the patient.
- O.K. to fax to my home
- O.K. to fax to my place of work

Print Patient's Name: _____ DOB ____/____/____

Print name of person completing this form: _____ Today's Date: ____/____/____

Your Signature: _____ Relation to Patient: _____