RANKIN Children's Group

1405 Crossgates Drive, W., Brandon, MS 39042 • 601-825-0925
281 Belle Meade Pt., Suite A, Flowood, MS 39232 • 601-992-2292

Joseph D. Edwards, Jr., M.D. • W. Craig Flowers, M.D. • Ann Marie Lee, M.D. • Laura B. Mullins, M.D.
Michael A. Rogers, M.D. • Emily Thomas, M.D. • K. Michelle VanNorman, M.D. • Alisha S. Vaughn, M.D.

NEW PATIENT INFORMATION

COMPLETELY FILL OUT

Date: _____ PLEASE PRINT

List all children in your family (biological/adopted) that will be a patient of this practice. This form must be **COMPLETELY** filled out. We can **NOT** verify that we have the most **current** information on file if you write, **"ALREADY ON FILE."**

1. Child's Full Name

_____
(First) (Middle) (Last)

Sex _____ Race _____ DOB _____ SS# _____

2. Child's Full Name

_____
(First) (Middle) (Last)

Sex _____ Race _____ DOB _____ SS# _____

3. Child's Full Name

_____
(First) (Middle) (Last)

Sex _____ Race _____ DOB _____ SS# _____

Preferred method of appointment reminders: (Mark one) Phone call _____ Text Message _____

Mailing Address:

_____
(Street or PO Box) (City) (State & Zip)

Primary Phone: _____ Home Phone: _____

If parents are not living together, with whom do the children live with? _____

Mother's Name: _____ DOB: _____
Mother's SS#: _____ Cell Phone: _____
Mother's Address **IF** not living with the child(ren) _____
Email Address: _____
Place of Employment: _____ Work Phone: _____

Father's Name: _____ DOB: _____
Father's SS#: _____ Cell Phone: _____
Father's Address **IF** not living with the child(ren) _____
Email Address: _____
Place of Employment: _____ Work Phone: _____

Emergency Contacts, Other than parents:

Relationship:
Name: _____ _____ Phone _____

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PATIENT MEDICAL HISTORY

Patient Information

Name: DOB: / / Sex: ☐ Male ☐ Female

Form completed by: Date completed: / /

Birth History

Were there any medical problems during pregnancy? ☐ Yes ☐ No

During the pregnancy did the mother ☐ smoke ☐ drink ☐ use drugs ☐ use medication _____

Hospital of Birth: _____

Baby born ☐ term ☐ early ☐ late at _____Weeks The delivery was ☐ Vaginal ☐ C-section Birth Weight: _____

Were there any problems after birth? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Any other important information regarding the birth? ☐ Yes ☐ No If yes, explain: _____

_____

General Medical History

Do you consider the patient to be in good health? ☐ Yes ☐ No Explain: _____

Does the patient have any serious medical conditions? ☐ Yes ☐ No Explain: _____

Has the patient had any serious injuries or accidents ☐ Yes ☐ No Explain: _____

Has the patient ever had surgery? ☐ Yes ☐ No Explain: _____

Has the patient ever been admitted to the hospital? ☐ Yes ☐ No Explain: _____

Is the patient allergic to any medications? ☐ Yes ☐ No Explain: _____

Developmental History

Are you concerned about the patient's physical development? ☐ Yes ☐ No Explain: _____

Are you concerned about the patient's mental or emotional development? ☐ Yes ☐ No Explain: _____

Are you concerned about the patient's attention span? ☐ Yes ☐ No Explain: _____

Are there any concerns related to school (behavior, academics)? ☐ Yes ☐ No Explain: _____

Family History

Is there any significant family history? Please explain (relation, medical problem) _____

_____

_____

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GUARANTOR AND INSURANCE INFORMATION

Name of Responsible Party: _____

Who should receive billing statements: _____

Address of Responsible Party: _____

PLEASE NOTE: If **each** child is insured by a parent, guardian, or a sibling **completely** list the insured's info below. If each child has a **different** ID or **different insurance,** please ask for additional forms. If your child(ren) has multiple insurance, it is your responsibility to inform RCG which is primary. We want to ensure that RCG is filing the claim appropriately. The only secondary insurance that RCG will file is **Blue Cross Blue Shield**. It will be your responsibility to file any other secondary insurance.

Primary Insurance-

Insured's Name: _____DOB _____
SS# of Insured: _____Effective Date of Policy_____
Insurance Co._____
ID # _____Group # _____
Lab Deductible $
Co-Pay $ _____ _____ Deductible $ _____

Secondary Insurance - BLUE CROSS BLUE SHIELD ONLY

Insured's Name: _____DOB _____
SS# of Insured: _____Effective Date of Policy_____
Insurance Co._____
ID # _____Group # _____
Lab Deductible $
Co-Pay $ _____ _____ Deductible $ _____

Financial Arrangements:

Payment is due at the time of service by the person bringing the child in for treatment. Any balance over 60 days old is the guarantor's responsibility. Payment arrangements can be made to avoid collections. If the account becomes delinquent, I agree to pay collection costs (33%-40%) & fees incurred in attempting to collect this account. I give my consent to receive communications from Rankin Children's Group and/or any collectors through various means such as cell or landline phones, text, email, auto dialer system, voicemail, & other forms of communications.

X_____ _____
(Print name of responsible person) **(Relationship to patient)**

X_____
(Signature of responsible person)

I would like to discuss the office's payment policy. **Yes** **No**

OFFICE USE ONLY
Child 1 - Account # _____
Child 2 - Account # _____
Child 3 - Account # _____

Employee Initials_____ **Date added to OP** _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

PLEASE FILL IN COMPLETELY*

Physician or Clinic to provide records: _____

City/State: _____ Office #: _____ Fax #: _____

Patient's Full Name: _____

Street or P. O. Box: _____ City/State/Zip: _____

Social Security Number: _____ Date of Birth: _____

Please indicate which location you prefer your medical records to be mailed to by marking "X" below:

☐ **Rankin Children's Group, PLLC**
1405 Crossgates Dr. West
Brandon, MS 39042

OR

☐ **Rankin Children's Group, PLLC**
281 Belle Meade Pt, Suite A
Flowood, MS 39232

Release these records:	Initials
1. Only records generated by this facility (not including records received from other sources).	_____
2. Only some portion of records maintained at facility (date of treatment, etc. or specify below).	_____
3. **ALL** Medical Records at this facility including records from other clinics/doctors.	_____

For #2 above _____
_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release information specified to Rankin Children's Group, PLLC, with the exception of: (PLEASE INITIAL FOR EXCEPTION).

_____ Substance Abuse, if any
_____ AIDS/HIV, if any
_____ Psychological or psychiatric conditions, if any
_____ Other (please specify) _____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire twelve (12) months after the date affixed below.
Use of Copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Person Authorized to sign for patient (print name): _____

Relationship to Patient: _____ My Telephone Number: _____

Signature of Authorized Person: _____ Date: _____

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AUTHORIZATION AND RELEASE

I am aware that I am financially responsible for any services that are deemed non-covered by my insurance carrier. This may include the following, but is not limited to this list:

- I authorize and request my insurance to pay directly to the doctor or doctors group any insurance benefits otherwise payable to me.
- I understand that my insurance is a contract between my insurance company and me, and I am responsible for notifying RCG of precertification and advising of any limitations, referrals, etc., required for compliance with this agreement.
- Co-payments, co-insurance, and deductibles**. It is my responsibility** to know what my co-pay, co-insurance, and deductible amounts are, and if any procedure requires pre-certification for services such as CT, MRI, Hospitalization, etc. If co-pays are not paid on the day services are rendered, you may be charged a $10.00 fee.
- **Non-covered** routine/wellness immunizations and lab procedures**. It is my responsibility** to know what wellness services/immunizations my insurance company will/will not pay for and if I have a maximum yearly benefit amount**. It is my responsibility** to inform the provider/nurse if they are not covered and if I refuse for them to be performed.
- Out-of-Network claims. **It is my responsibility** to make sure I am utilizing an In-Network Provider.
- Untimely filing, because the parent failed to provide insurance information in a timely manner**. It is my responsibility** to provide **a current** copy of my insurance card at the time of service. (Aetna, CHIP, & United Healthcare). **United Healthcare & CHIP** has to be filed within 90 days. **Aetna** has to be filed within 180 days.
- Elective procedures that the parent request when there is no medical indication/family history for the requested tests.
- Missed sick/wellness appointments. The first missed sick/wellness appointment (per family, not per child) will not be billed, but any subsequent appointments will be charged to the account if **a one-hour notice is not given. The current charge is $50.00.**
- Special appointments or ADD/ADHD appointments will be charged to the account for the **first** missed appointment if a **24-hour notice is not given. The current charge is $100.00.**
- Same-Day Prescription fees when a prescription is needed the same day. **A one-week notice (7 days) is required** for ADD/ADHD prescriptions.
- Medical records. The first copy to the parent is free. There will be a charge for any additional copies requested.
- Recuperation of any insurance payments from your insurance company for non-covered services paid in error or an insurance that has terminated and paid in error.
- Out of State or lengthy phone conversations with a **physician** per the parent's request.
- If certain clinical lab work is positive, additional labs **may** be performed by the outside lab facility or for missed unmarked lab. In the event that additional testing is necessary, your account will be billed at that time.
- **I understand** that **secondary policies are not filed unless the secondary is Blue Cross**. **It is my responsibility** to know which insurance is primary/secondary, if there are two policies. I understand that I **don't** get to choose which one is primary, and if I don't know which is primary and secondary, a claim will **not** be filed until it is known. Any other secondary policy will be **my** responsibility to file if it is not Blue Cross. I will be responsible for my primary co-pay, deductible, co-insurance at the time of service.
- **I understand that by refusing to sign this waiver or revoking this waiver, this organization may refuse to treat my child/me.**
- **As a parent or legal guardian of the child listed below, I give the doctors of this group permission to examine and treat my child.**

_____
Date

_____ _____
Printed Name of Child **Account Number (office use only)**

_____ _____
Printed Name of Parent if minor child/or parent **Signature of Parent if minor child/or patient**

Rankin Children's Group, PLLC
HIPAA

Patient Consent for Use and Disclosure of Protected Health Information

HIPAA legislation grants patients several rights, among them greater access to and control over their medical records. This form is in effort to protect your information as well as protect our clinic from possible HIPAA violations.

I understand that as part of my child/children('s) health care, Rankin Children's Group, PLLC, which will be from this point forward referred to as RCG, originates and maintains paper and/or electronic records describing my child/children('s) health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child/children('s) care and treatment.
- A means of communication among the many health professionals who contribute to care.
- A source of information for applying the diagnosis and surgical information to my bill.
- A means by which a third-party payer (insurance company) can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that RCG is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat my child as permitted by *Section 164,506 of the Code of Federal Regulations.*

I further understand that RCG reserves the right to change their notice and practices and prior to implementation, in accordance with *Section 164,520 of the Code of Federal Regulations.* Should RCG change their notice, they will provide me a copy of any revised notice upon my next visit.

The following people have access to my child/children('s) record, in addition to the mother and father of the child, unless their parental rights have been legally revoked:

**** In addition to the mother and father of the child, the following people may make and appointment or bring my child in for any appointment scheduled.**

_____

_____

I understand that the above listed names have full access to my child/children('s) record including billing information and account balance. I understand that RCG will verify to the best of their ability the identity of the listed people. I also understand that RCG may refuse to disclose any information if their identity is in doubt.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:

Parent's Signature: _____ Date: _____