PONY EXPRESS PEDIATRICS

PATIENT DEMOGRAPHICS (CHILD'S INFO)

Child's Last Name: _____ Child's First Name: _____ MI: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Sex: _____ _____

Parent/Guardian Name & Relationship: _____ & _____

Address: _____ City/State/Zip: _____

Home Phone/Cell (MOTHER): _____ Email: _____
Home Phone/Cell (FATHER): _____ Email: _____

Primary Care Doctor or Clinic: _____ or _____

Preferred Pharmacy & Location: _____ & _____

How did you hear about us? Please Circle:

Doctor referral Relative/Friend Building/signage Medical/Insurance directory
Social Media – Facebook Twitter Instagram Mailer Magazine/ Newspaper

Race (optional): Please Circle:
White African American Pacific Islander Asian Native American

Ethnicity (optional):
Non-Hispanic/Latino Hispanic/Latino Other

Emergency Contact Name: (can be parent) _____ Phone #: _____

DO WE HAVE PERMISSION TO? Please Circle:

Leave personal information on your voicemail, including but not limited to lab or other test results?

Yes No

Discuss your medical information with family members? Please Circle: Yes No

If Yes, Name: _____

INSURANCE INFORMATION: GUARANTOR (PARENT/GUARDIAN INSURANCE POLICY HOLDER/PAYMENT)

(Print) Full Name of Parent/Guarantor & Relationship to PATIENT: _____

TRICARE INSURANCE ONLY Sponsors Social Security #: _____

Address (if different than PATIENT): _____

MOTHER'S Date of Birth: _____ FATHER'S Date of Birth: _____

Full Name of INSURED/PATIENT: _____

Address of Insured (if different than PATIENT): _____

Phone of Insured (if different): _____

Primary Insurance Company Name: _____

Policy Number: _____

Group Number: _____

Secondary Insurance Company Name: _____

Policy Number: _____

Group Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the practitioner. I understand that I am financially responsible for any balance. I authorize Pony Express Pediatrics, LLC After-Hours Clinic, or my insurance company to release any information required to process my claims. I also authorize the above communication permissions as checked, which will expire one year from the date signed.

I, as the parent or guardian of the above-named patient, give consent to Pony Express Pediatrics, LLC After-Hours Clinic, the Practitioners, and other personnel on its medical staff to administer such care, procedures and treatment that are deemed necessary and in the best interest of the patient. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved. I impose no specific limitations or prohibitions regarding treatment other than those that follow _____ (if none, leave blank)

PATIENT Name (Print): _____
Parent/Guardian Name & Relationship (Print): _____

Parent/Guardian SIGNATURE: _____ Date: _____

PATIENT FINANCIAL POLICY

Welcome to Pony Express Pediatrics, LLC After-Hours clinic. We are committed to providing the best possible healthcare to you and your family. Understanding your financial responsibility is an essential element of your medical care and treatment.

INSURED PATIENTS: Our office policy is to collect the patient's responsibility for medical care provided at the time of service. We are here to help answer questions you may have regarding your insurance and payments. It is important to understand that your health insurance policy is a contract between you, your employer, and your insurance carrier. It is your responsibility to know what your policy benefits cover. We will collect your co-pay/deductible and file your claims directly to your insurance company. Deductible amounts are based on an estimate of your contracted rate. After your claim has been processed, you will receive a statement for any difference your insurance company applies to your responsibility. In the event your health plan determines a service is "not covered," you will be responsible for the balance upon receipt of a statement from our office.

UNINSURED/SELF-PAY PATIENTS: We understand that not all of our patients have health insurance coverage. Our office policy for self-pay patients is very simple: we utilize the same fee schedule for uninsured patients as we do for those with insurance. At the time of service, we will collect payment in full for all services provided. Ask the front desk personnel for current estimated office visit costs.

PROMPT PAY DISCOUNT: We offer a 30% discount off our standard fee schedule for all charges paid in full by self-pay patients at the time of the visit. The prompt pay discount is a courtesy for payment IN FULL at the time of service and does not apply to insurance discounted rates.

MEDICAID/CHIP: We do bill Medicaid for all Wyoming Medicaid patients. Co-Pay will be at the time of service.

MINOR PATIENTS: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent/guardian with custody for payments

Please be aware that if it is medically necessary for the practitioner to order blood work, you will receive a separate bill from the lab that the blood work is processed through.

We encourage you to call our billing office should you require assistance with your statement. A $25.00 fee is added to your account if it is sent to collection and for non-sufficient funds returned check/credit card fees. I have read and understand Pony Express Pediatrics, LLC After-Hours Clinic's FINANCIAL POLICY. I agree to be bound by its terms.

CHILD Name (Print): _____ Parent/Guardian Name (Print): _____

Parent/Guardian SIGNATURE: _____ Date: _____

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS &
AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION: I authorize Pony Express Pediatrics, LLC After-Hours Clinic to release any third-party payer or consulting physician/practitioner any medical records concerning diagnosis and treatment when requested for its uses in connection with determining payment of services rendered and/or further treatment and/or diagnosis.

HEALTHCARE PROVIDER INSURANCE ASSIGNMENT: I authorize payment directly to Pony Express Pediatrics, LLC After-Hours Clinic for its services as described but not to exceed the reasonable and customary charge for service. I understand that my insurance may or may not be in-network with Pony Express Pediatrics, LLC After-Hours Clinic and/or the practitioner providing services. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third part within a reasonable period of time (not to exceed 60 days).

MEDICARE/MEDICAID PATIENTS ONLY: I authorize payment directly to Pony Express Pediatrics, LLC After-Hours Clinic and authorize the release of medical information to the centers for Medicare and Medicaid Services (CMS) and its agents. In Medicaid-assigned cases, the practitioner agrees to accept the allowed charge determination of the Medicaid carrier and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance & deductible are the determination of the Medicare/Medicaid carrier.

I PERMIT A PHOTOCOPY OF THE AUTHORIZATION & ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT Pony Express Pediatrics, LLC: This assignment will remain in effect until revoked by me in writing. I understand that it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid by my insurance or third-party payer. Should my check for payment be returned for any reason, Pony Express Pediatrics, LLC After-Hours Clinic will assess a $25.00 return check fee to your account. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections. A $25.00 fee will be added to your account if it is sent to collections.

CHILD Name (Print): _____

Parent/Guardian Name (Print): _____

Parent/Guardian SIGNATURE: _____Date: _____

PATIENT ACKNOWLEDGEMENT & CONSENT

The federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with HIPAA's requirements, we will provide you with a copy of our Notice of Privacy Practices upon request at any time. The Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as explained in our Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES: By signing this form, you acknowledge that you have been offered/given and have had an opportunity to read our Notice of Privacy Practices. Our notice provides a description of our treatment, payment and policies, healthcare operations, and your rights as a patient. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revision, at any time by contacting us at the above address.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation. You understand that the revocation of this consent will not affect any action we took in reliance on the consent before we receive the revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had a full opportunity to read and consider the contents of Pony Express Pediatrics, LLC After-Hours Clinic's PATIENT ACKNOWLEDGEMENT & CONSENT and the NOTICE OF PRIVACY PRACTICES of Pony Express Pediatrics, LLC After-Hours Clinic. I understand that by signing this consent form, I am giving my consent for Pony Express Pediatrics, LLC After-Hours Clinic to use and disclose my Protected Health Information to carry out treatment, payment activities, and healthcare operations.

CHILD Name (Print): _____

Parent/Guardian Name (Print): _____

Parent/Guardian SIGNATURE: _____ Date: _____