Centennial Pediatrics, PA

Patient Registration

Today's Date_____

Patient Information:

Pt's Full Name: _____ DOB: _____ Male ☐ Female ☐

Physician: Dr Guetersloh ☐ Dr. Nail ☐ Dr. Newton ☐ Dr. Crow ☐ Dr. McClendon ☐ Dr. Bridgewater ☐ Dr. Katz Lestz ☐

List of Siblings

Name: _____ Male ☐ Female ☐ Date of Birth _____

Name: _____ Male ☐ Female ☐ Date of Birth _____

Pharmacy Information

Name_____ Phone Number_____ Address _____

Mother / Guardian Information - 1		Father / Guardian Information - 2	
Name:		Name:	
Date of Birth:		Date of Birth:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Employer:		Employer:	
Best # to call:	Please specify- cell, home, work	Best # to call:	Please specify- cell, home, work
Alternate #:	Please specify- cell, home, work	Alternate #:	Please specify- cell, home, work
Home Email:		Home Email:	
Work Email:		Work Email:	
Relationship to Pt:		Relationship to Pt:	
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced		Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	

Guarantor / Responsible Party: _____

In cases of separated or divorced parents, who is the custodial parent? _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues : Home Phone / Cell / Work ***Appointment Reminders*** : Call / Text / Home Email

Billing Statements : Home Address / Home e-mail ***Patient Portal Notifications:*** Home Email / Work Email

Recall/General Practice Notices : Home Email / Work Email

Signature: _____ Date: _____

Signature here allows us to leave messages at the numbers listed above via voicemail, person, etc.

Emergency Contact - OTHER THAN PARENT

Name of Contact: _____ Male ☐ Female ☐

Home Phone: _____ Cell: _____ Work: _____

Relationship to Child: ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Other Person(s) Allowed to Bring Patient to the Office or receive medical information/advice

Name of Contact: _____ Male ☐ Female ☐ Best Phone # _____

Relationship to Child: ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Name of Contact: _____ Male ☐ Female ☐ Best Phone # _____

Relationship to Child: ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Parent/Guardian Signature _____ **Date**_____

Authorization to Release Patient Information

I authorize Centennial Pediatrics (Chad D. Guetersloh, M.D., Christopher L. Newton, M.D., Richard C. Nail, M.D., Susan W. Crow, M.D., Dr. McClendon, Dr. Bridgewater, Dr. Katz Lestz) or their covering physicians (collectively referred to as "Physician") or their designee to release and furnish all medical and financial data for purposes for utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations contracting with any of the above to perform such functions.

Authorization for Treatment

I authorize and give my consent to the Physician at Centennial Pediatrics to treat my child, as he/she deems medically necessary in the event of my absence.

Authorization for Payment

If I am a member of a health care plan, of which Physician is an authorized provider, I understand that I must present my Health Plan identification at each visit or I agree to pay the charges billed by my physician at the time of the visit. If I am a member of an HMO, EPO, or POS health care plan that requires me to choose a primary care physician, I must choose a physician from this practice before my child's visit and the insurance card that I present must include this physician's name that is rendering services. I understand that I am responsible for all copayments and deductibles under the plan and must pay them at the time of the visit.

In the event I request that my Physician provide medical services, lab procedures or immunizations which are not authorized or covered by my health care plan, I hereby agree in advance, to pay the Physician the customary billed charges for such services. In the event that my Physician does not perform certain in-office lab services under my health care plan and I request that the Physician perform such lab services in his office for my convenience, I agree to pay the Physician his billed charges since this service is considered to be "out of network".

I authorize payment of medical benefits to CENTENNIAL PEDIATRICS. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to CENTENNIAL PEDIATRICS. This assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Acknowledgement of Receipt and Review of Financial Policies

I have received and reviewed this office's Financial Policy, which explains how my financial responsibilities to Centennial Pediatrics. The document can be obtained at the office of Centennial Pediatrics, PA or on their website http://centennialpediatrics.net/office-visit-policies

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. The document can be obtained at the office of Centennial Pediatrics, PA or on their website **http://www.centennialpediatrics.net/patient-forms.html**

My signature below indicates that I have read, understand, and agree to the above terms.

Child's Name: _____ **Parent/Guardian Signature:** _____

Child's Name: _____

Child's Name: _____ **Date:** _____

Child's Name: _____

Child's Name: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Previous Physician or Practice Name

Address

Phone Number and Fax Number

I request that my child's complete records or specific information as listed below be released to:

Centennial Pediatrics
5560 Independence Parkway
Frisco, TX 75035
214.389.8801 phone
214.389.8802 fax

Patient's Name and Date of Birth

Parent's Signature and Date

Information Requested

Reason for Request

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to the facility receiving the revocation.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be re-disclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

CENTENNIAL PEDIATRICS, PA

Chad Guetersloh, M.D. * Christopher "Kit" Newton, M.D., PhD * Richard Nail, M.D.*
Susan Crow, M.D. * Laura McClendon, M.D. * Erin Bridgewater, M.D. * Leslie Katz Lestz, M.D.

Authorization to Charge Credit Card

As healthcare policies continue to change and there is a significant increase in deductibles and coinsurance, we are asking that a credit card be kept on file. This significantly helps reduce costs for our office. All balances are due at the time of visit.

I authorize Centennial Pediatrics, PA to charge the below listed credit card for any outstanding balances that is incurred for visits, treatments, and after hour nurse calls. I understand that Centennial Pediatrics will contact me by phone for transactions over $100 for my permission. Receipts will be mailed following any credit card transaction. Credit card information will be kept secure and confidential.

Patient's Name _____DOB_____

Patient's Name _____DOB_____

Patient's Name _____DOB_____

Patient's Name _____DOB_____

I understand that this authorization will be valid thru the expiration of my credit card, unless I cancel this authorization through written notice.

O MasterCard

O Visa

_____
Cardholder Name

_____
Billing Address, City, Zip

_____ _____
Account Number Expiration Date

Signature_____ Date_____

Centennial Pediatrics
Financial Policy

Thank you for choosing Centennial Pediatrics for your child's medical care. We are committed to providing you and your child/children with the highest quality of care possible in the most economical way possible. As part of our relationship with you, we want you to have a clear understanding of our financial policy.

As you are probably aware, employers are selecting healthcare plans that have increasingly transferred costs to you (the insured). This is due to high deductible and larger coinsurance plans. Because of this, we need to implement certain payment policies to be able to continue to provide the best care possible for your child/children.

Items to bring to each appointment:

- Insurance Card
- Method of Payment

Insurance

- We are contracted with several different plans including PPO's and HMO's. As a courtesy, we will file the medical claim directly to the insurance plan.
- Please make us aware of any changes to your insurance. If you fail to do so, the balance will be your responsibility. We are obligated to file claims within a certain timeframe. We will not be held accountable if you fail to give us updated insurance information at the time of visit.
- If your insurance denies the claim because they need additional information from the member, please help us by providing the information to the insurance company as soon as possible. If the claim continues to deny because the information was not received, the full balance will become your responsibility.
- **It is always best to contact your insurance company to ensure we are participating with your plan and services will be covered.**

Credit Card Authorization Forms

Centennial Pediatrics accepts MasterCard and Visa. A credit card must be kept on file. By providing Centennial Pediatrics with specific credit card information, we will not have to telephone you when a co-payment was not received at the time of service.
Credit Card information on file can also be used to pay your remaining balance after your insurance company has processed your claim.

Healthcare Reform

Healthcare Reform has created several new Plans/Names and continue to add additional plans. Due to the increase, it is difficult for our office to keep up with all of the new plans formed. Until further notice, the only plans that we are participating with through the Healthcare Reform is Molina & BCBS HMO Advantage.

Listed below are plans we are certain we do not participate in. There could be additional plans that we are not participating with; therefore, it is the responsibility of the patient/parent to contact their insurance company to ensure we are in network.

- Aetna EPO(Bronze, Silver, Gold)
- Amerigroup
- Ambetter
- Cigna Focus
- Cigna Health Flex
- Cigna-mycigna health savings
- Chips
- Medicare
- Medicaid
- Scott & White Health Plan
- Tricare

Co-Payment and other fees

- **Effective Sept 1, 2014, we will no longer accept personal checks**
- **Copays-** As participating providers with your insurance plan, it is required to collect your copayment on the date of service. If payment is not received at the time of visit, you must call in and make payment prior to the end of day. If we do not receive payment by the end of the day, a $10 late fee will be applied.
- **Uninsured-**If you have no insurance coverage, payment is due at the time services are rendered. **A credit card will need to be kept on file.**
- **After Hour Calls- <u>As of May 1st, 2017 a $15.00 fee</u>** will be incurred for after hour calls
- **No Show Fee-**Failure to cancel your appointment within 24 hour notice will result in a $25.00 charge
- **Nurse Visit-** A $20.00 charge will be incurred for nurse visits
- **Forms-** A $10 charge will be incurred for all forms and letters that require more than a signature. These are often lengthy and take extra time to be completed. Please all up to 4 business days for these to be completed.
- **Late Fee-**If payment is not received in a timely manner, your account will be billed a $25 late fee per monthly billing cycle. After three (3) billing cycles your account will be turned over to a collection agency and you will be responsible for all service fees.
- **Returned Checked-** $35 will be charged for any checks that are returned NSF.
- As the guarantor, you are responsible for all remaining balances after the insurance has paid. This includes coinsurance, deductibles, and non-covered services.
- **Payments on any outstanding patient balances are due at time of visit.**
- If the patient is a minor (anyone under the age of 18) a parent or legal guardian must be in attendance to give consent for treatment and be the responsible guarantor.
- In a divorce situation, the parent who brings the dependent child to our office is responsible for payment. Insurance may be filed, but the parent in attendance will be responsible for any copayment or outstanding balances.

Past Due Accounts

Statements are mailed out on a monthly basis. An account becomes delinquent after 2 statements have been sent out and no payment has been received. A $25 late fee will be added to the account. Payment will need to be made on the account prior to making a well visit appointment.

If no payment has been made on an account after 4 billing cycles, the account will be turned over to collections and you will be discharged from the practice. A certified letter will be sent to you and you will have 30 days to find another pediatrician.

We will work with you to make payment arrangements and set up a payment plan if necessary.

Sincerely,
Centennial Pediatrics