Salmon Falls family healthcare

Child Patient Patient Registration and Consent for Treatment Financial Policy, Consent for Billing & Receipt of Documents

Child Patient Name (First, MI, Last):_____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____/_____ /_____ **Marital Status:** ☐ Single ☐ Married **Social Security #**: _____ - _____ - _____

Mailing Address:_____ **City/State:** _____**Zip Code:** _____

Street Address:_____ **City/State:** _____**Zip Code:** _____

Phone (Home):_____ **Phone** (Cell):_____ **Phone** (Work):_____

Email: _____

Race
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Other: _____
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander

Preferred Language
- ☐ English
- ☐ Other:_____

Ethnicity
- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Other

*We may wish to communicate upcoming appointment information, test results and/or other information regarding medical care. What is the best phone number for contact where we may also leave messages? ☐ Home ☐ Cell ☐ Work

Parent/Guardian

1) Name:_____ Gender: ☐ Male ☐ Female
   Relationship to Patient:_____ Date of Birth:_____
   Mailing Address:_____ Social Security #:_____
   City:_____ Phone:_____(Primary)
   State, Zip code:_____ _____(Secondary)

2) Name:_____ Gender: ☐ Male ☐ Female
   Relationship to Patient:_____ Date of Birth:_____
   Mailing Address:_____ Social Security #:_____
   City:_____ Phone:_____(Primary)
   State, Zip code:_____ _____(Secondary)

Additional Contacts/Emergency Contacts: this person has permission to …

Name	**Relationship**	**Phone**	Discuss child's health information	Pick up child's prescription from office	Bring child to appointment

***If a person is not listed on this form a signed permission from a parent/guardian accompanied by person's photo identification would be required.*

PATIENT: Please initial this page ☐ **and continue to Page 2 & 3 for signature** CPS Update/Staff Initial ☐

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Financial Policy, Consent for Billing & Receipt of Documents

Child Patient Name (First, MI, Last):_____ **Date of Birth:** _____/_____ /_____

Insurance Information* *(fill out completely)*	
Primary Insurance: _____	*Secondary Insurance*: _____
Insurer ID#:_____	Insurer ID#:_____
Group #:_____	Group #:_____
Claims Address: _____	Claims Address: _____
Subscriber: _____	Subscriber: _____
Subscriber's Date of Birth:_____	Subscriber's Date of Birth:_____
Relationship to patient:	Relationship to patient:
☐ Self ☐ Spouse ☐ Other	☐ Self ☐ Spouse ☐ Other

Workers Compensation

Company _____ Address _____

Claim # _____ Date of Injury _____ Body Part Covered _____

Case Manager _____ Phone Number _____ Ext_____

Employer at time of injury_____ Contact Name/Phone_____

Attorney Name_____ Phone_____

PATIENT: Please initial this page ☐ **and continue to Page 3 for signature** CPS Update/Staff Initial ☐

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Payment Policy:
We ask that you read through the financial policy and sign the bottom prior to treatment. Co-pays are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge on any returned check; payment in full will be required within 10 days of notice.

Insurance:
Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility. You as the policy holder are responsible for choosing a primary care provider if required. If you cannot show proof of a Salmon Falls Family Healthcare provider chosen as your PCP you will be billed for unpaid charges by your insurance company.

Insurance Referrals:
If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Missed Appointments:
If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as courtesy to the doctors, staff and other patients. If you cancel or "no-show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.
Please let us know if you have any questions regarding our Financial Policy.

The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.
I consent to evaluation and treatment by any provider at Salmon Falls Family Healthcare. I hereby authorize release of medical information that is necessary for my further treatment.
I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates.
I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.

Patient Name (Please print):_____ DOB _____

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print): _____ Relationship: _____

**** Receipt of Documents ***Patient: Complete below at the SFFH Office*** ****

I have received and understand the information contained in the following documents:

1. Notice of Privacy Policies
2. Patient Bill of Rights
3. Patient Responsibilities
4. Patient Complaint Procedure
5. Advance Directives Information

PATIENT/Authorized Person SIGNATURE: _____ Date: _____