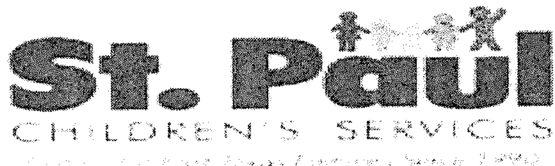


FINANCIAL POLICY

Definitions: "I," "me," and "my" mean the patient. "Clinic," means ST PAUL CHILDREN'S CLINIC, together with its affiliated entities and its employees. I am signing this agreement to obtain services. A photostatic copy of this form shall be as effective and valid as the original.

We are committed to providing you with quality care. If you have health insurance, we want to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Our physicians/facilities participate in a number of HMO and PPO networks. It is your responsibility to verify that the doctor/facility you are seeing is "in network". Please verify this by calling the "800" telephone number on your group insurance card or check with your employer on how to obtain this information.

Copayments are collected on each visit. If you are not insured by one of the participating HMO or PPO insurance companies, payment will be collected according to your plan's out-of-network benefits. If you carry no medical coverage, payment in full is required at the time of your visit unless prior arrangements have been made. We accept cash, checks, MasterCard, Visa, and Discover. *You may receive additional bills for services in addition to the physician's professional services such as services for laboratory.*

Medicaid: We accept Medicaid. Your actual co-insurance payment amount depends on the services you receive today from your physician.

If treatment is sought due to a motor vehicle accident or other personal injury, you will be responsible for your bill, i.e., office visits, X-rays, any tests or procedures and/or subsequent surgery. We do not accept any third - party insurance or letters of protection from attorneys.

If you are seeking treatment for an injury that occurred on a school campus, you must bring a claim form completed by the appropriate school official. This claim form should include details of the accident and the name and address of the school's insurance company.

We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. There will be a $30 charge for all returned checks. We do not accept post-dated checks.

I HAVE READ AND COMPLETELY UNDERSTAND THE FINANCIAL POLICY OF THE ST PAUL CHILDREN'S CLINIC. FURTHERMORE, I UNDERSTAND AND AGREE THAT ANY CREDIT BALANCE I MAY HAVE WITH ST PAUL CHILDREN'S CLINIC MAY BE APPLIED TO SATISFY ANY DEBT I MAY HAVE ON AN ACCOUNT WITH ST PAUL CHILDREN'S CLINIC OR ANY OTHER ACCOUNT WITH ST PAUL CHILDREN'S CLINIC.

______________________________ ____________________

Signature of Patient and/or Responsible Party Date

ST. PAUL CHILDREN'S CLINIC

MRN: @MRN@ @TMFSEX@
@NAME@
Date of Birth: @DOB@

HIPAA PROTECTED HEALTH INFORMATION—ACCESS FORM

I understand that state and federal laws permit ST PAUL CHILDREN'S CLINIC to share information about me, including information regarding the health care services I received (my Protected Health Information), with my family and friends who are involved in my care or the payment of my health care services. I further understand that I have: (i) the right to grant certain persons access to my Protected Health Information; and (ii) the opportunity to restrict access to my Protected Health Information from certain individuals who might otherwise have access. I understand that granting access **DOES NOT** give the person access to copies of my medical records.

ACCESS: I would like for the following person(s) to have access to my Protected Health Information.

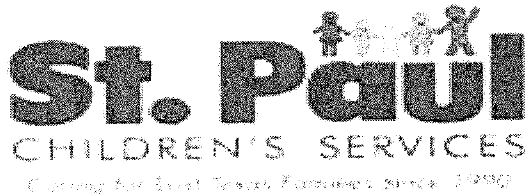
NAME(S) (PLEASE PRINT)	DOB
1.	
2.	
3.	
4.	
5.	

I understand that I may change or revoke this form at any time by contacting ST PAUL CHILDREN'S CLINIC. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

__ You may leave confidential clinical information on my answering machine/voice mail

Signature of Patient/Responsible Party	Date	Witness Signature

MRN: @MRN@ CSN: @CSN@
@NAME@ @TMFSEX@ @DOB@



Authorization to Obtain Care for Minor

Legal Guardians of Minor:

Name	DOB	Relationship
____________________	____________	__________________
____________________	____________	__________________
____________________	____________	__________________

I, ________________________ as parent of legal guardian of said minor, ____________________ (Child's Name)

____________________ (Child's DOB) do give permission for the following individuals to seek and receive any and all medical treatment for the above named minor:

Name of Individual	DOB	Relationship
____________________	____________	__________________
____________________	____________	__________________
____________________	____________	__________________
____________________	____________	__________________
____________________	____________	__________________

This document will remain in effect until cancel in writing.

________________________________ Signature of parent or legal guardian

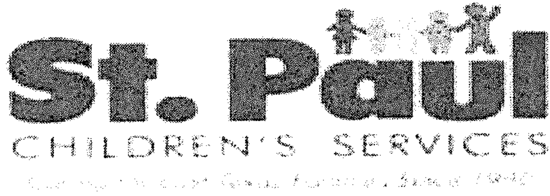
________________ Date

________________________________ Witness

________________ Date

ST PAUL CHILDREN'S CLINIC

@MRN@
@NAME@
@DOB@



NO SHOW POLICY FORM & ACKNOWLEDGMENT OF PATIENT AND FACILITY RIGHTS AND RESPONSIBILITIES

Patient's Name:____

To best serve all our patients it is very important to fill every appointment with individuals that will show up for their given appointment.

If you miss three (3) appointments without calling to cancel or reschedule before your appointment time, we only see you for emergencies, then 30 days from that day your chart at our facility will be closed.

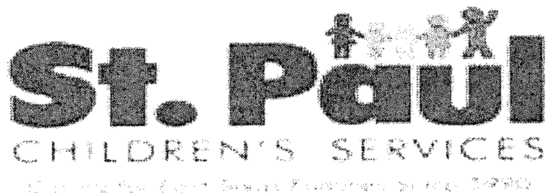
If Medicaid is your source of insurance and you miss three (3) appointments you may lose your Medicaid benefits.

I ____, understand that if I miss three (3) appointments, ________________________________, (the patient) will no longer be a patient at St. Paul Children's Medical Clinic and I may lose Medicaid benefits.

By signing I also understand that Patient and Facility Rights and Responsibilities of our medical practice. These rights and responsibilities are posted at all times and a copy may be issued to you at any given time upon request.

____

Parent/Legal Guardian Signature Date



PATIENT AUTHORIZATION

Definitions: "I," "me," and "my" mean the patient. "Clinic," means ST PAUL CHILDREN'S CLINIC, together with its affiliated entities and its employees. I am signing this agreement to obtain services.

If any part of this agreement is invalid, it will not affect the validity of the remainder of this agreement. Any invalid part will be deemed reformed to comply with the law. A photostatic copy of this form shall be as effective and valid as the original.

ASSIGNMENT OF BENEFITS

I certify that the information I gave in applying for payment of Medicaid benefits is correct. I irrevocably assign and transfer to Clinic all Medicaid and/or insurance benefits covering service for the payment of services rendered. I understand it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments and deductibles.

FINANCIAL RESPONSIBILITY

I understand that insurance coverage is not a guarantee of payment, and I agree that **I am ultimately responsible for payment for services rendered** at Clinic. I will honor the payment policy.

Automated Communications

I consent to receive automated communications via electronic mail, text messages, and/or telephone calls on my cellular phone, other phone(s), and other communication devices, including but not limited to, autodialed calls and pre-recorded or artifical voice messages from the Clinic, its affiliates, successors, assigns, agents, and servicers. I understand these communications may be regarding appointment reminders, or my financial responsibility for services provided to me. I understand these calls and messages may result in access fees from my cellular provider and I will be solely responsible for such fees. Consent may be revoked at any time by providing verbal or written notice to the Clinic Manager.

Agreement

By signing below, I agree to be bound by the provisions of this form.

____

Signature of Patient or Representative

____

Relationship to Patient

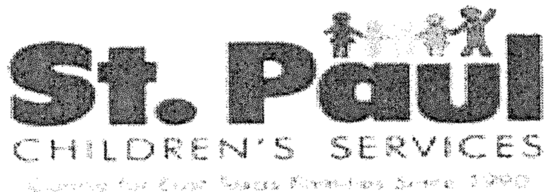
**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the Patient.*

____

Date

ST PAUL CHILDREN'S CLINIC

MRN: @MRN@ *@TMFSEX@*
@NAME@
Date of Birth: @DOB@



PATIENT CONSENT

Definitions: "I," "me," and "my" mean the patient. "Clinic," means ST PAUL CHILDREN'S CLINIC, together with its affiliated entities and its employees. I am signing this agreement to obtain services.

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Initials

CONSENT FOR TREATMENT

I authorize the independent physicians, the Clinic, and all other persons caring for me to treat me in ways they judge are beneficial to me, including, medical and surgical treatment, and preventative care including immunizations. I authorize the Clinic's employees to provide any and all necessary care during my treatment period to carry out all general and special orders of my independent physicians (including consultants, associates, and assistants of their choice).

I understand and consent that I may receive care that is provided by a Nurse Practitioner (NP) or Physician Assistant (PA). I understand that an NP and PA or any medical professional are Licensed Professionals who work within the Clinic under the supervision of my physician and that they may discuss my care with my physician for treatment purposes.

AUTHORIZATION FOR RELEASE AND/OR ACQUISITION OF INFORMATION

I hereby authorize the Clinic to release and/or acquire any necessary medical information to and/or from third parties, including but not limited to other health care providers, any insurance company or third party payor for the purpose of processing a claim, or otherwise as allowed by law. I release the Clinic from any liability for the release and/or acquisition of this information.

CONSENT FOR ELECTRONIC SHARING AND HEALTH INFORMATION EXCHANGE

I authorize Clinic to release and send my medical information to my non-Hospital/Clinic health care providers electronically and/or through a Health Information Exchange, an organization that provides services to enable the electronic sharing of health-related information. Medical information disclosed pursuant to this authorization may be used for treatment, payment, and operational purposes. The medical information disclosed may become part of my Clinic's health care providers' medical records and may be re-disclosed by the recipient and no longer protected by state and federal privacy laws. I understand that I can change my mind and withdraw this authorization at any time by providing verbal or written notice to the Clinic, but Clinic cannot take back information that has already been electronically shared. This consent is valid unless I have withdrawn it.

HIPAA NOTICE OF PRIVACY PRACTICES

The Clinic is required by federal and state law to maintain the privacy of your Protected Health Information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required to give you notice about our privacy practices and your rights concerning your PHI. By initialing this box, you acknowledge that you have been given or offered a copy of the "Notice of Privacy Practices" of Clinic.

____

Signature of Patient or Representative

____

Relationship to Patient

**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the Patient.*

____

Date

ST PAUL CHILDREN'S CLINIC

MRN: @MRN@ @TMFSEX@
@NAME@
Date of Birth: @DOB@
@ATTPROV@