PEDIATRIC PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

Your Child:

Child's Full Name: ______________________ Name Your Child Goes By: ______________

Gender: ❑ Male ❑ Female DOB: ______________ Age: ________ SS#: ______________

Child's Home Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ______________

Primary Physician: ______________________________

❑ Mother ❑ Stepmother ❑ Guardian

Name: ______________________ DOB: ______________

SS #: ______________ Home Phone: ______________ Work Phone: ______________

Employer: ______________________ Occupation: ______________

Cell Phone(s): ______________________ E-Mail: ______________

❑ Father ❑ Stepfather ❑ Guardian

Name: ______________________ DOB: ______________

SS #: ______________ Home Phone: ______________ Work Phone: ______________

Employer: ______________________ Occupation: ______________

Cell Phone(s): ______________________ E-Mail: ______________

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

PARENTAL MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: ______________

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards pertaining to child in order to file your insurance claims.

PRIMARY INSURANCE: ______________________ INS ID#: ______________

RELATIONSHIP TO SUBSCRIBER: ______________ SUBSCRIBER NAME: ______________

SUBSCRIBER'S ADDRESS: ______________________________

SS #: ______________ DOB: ______________ PHONE: ______________

SECONDARY INSURANCE: ______________________ INS ID#: ______________

RELATIONSHIP TO SUBSCRIBER: ______________ SUBSCRIBER NAME: ______________

SUBSCRIBER'S ADDRESS: ______________________________

SS #: ______________ DOB: ______________ PHONE: ______________

EMERGENCY CONTACT INFORMATION:

NAME: ______________ HOME PHONE: ______________ WORK PHONE: ______________

RELATIONSHIP TO CHILD: ______________

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

CONSENT FOR RELEASE OF MEDICAL INFORMATION:

I, ______________________________, parent/legal guardian of ____, grant permission for the person(s) listed below to have access to any and all of my child's medical information that pertains to his/her care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, his/her physician's plans for health care, etc.

Signature: ____

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

CONSENT FOR MEDICAL TREATMENT:

I, _________________________________, parent/legal guardian of ____,

grant permission for the person(s) listed below to bring my child to Galen Medical Group, PC for medical treatment.

Signature: ____

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.

Please list any siblings who are also patients of ours. Give both first and last names:

____ ____

____ ____

____ ____

____ ____

ADVANCED DIRECTIVES & AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group, PC and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

____ ________________________

Signature of Responsible Party / Insured ***Date***

THANK YOU!

Wisdom. Compassion. Integrity.

To Our Valued Patient:

Please note that we are not informed of your individual insurance benefits. Some insurance plans cover annual exams and/or well child visits and vaccinations at 100% and some plans do not. We also accept many insurance policies, but our office is not aware if we are on your individual plan or if we are in your network. It is the patients' responsibility to contact your insurance company regarding your benefits and/or providers prior to your visit. Once a claim is filed, we can not refile this claim with a different service or diagnostic code. If the services are denied by your insurance company, you will be responsible for payment of the services rendered.

I have read the above statement and understand that my visit scheduled as a Physical/Well Child Exam will be billed as a physical/well child exam. I also understand that I will be billed in the event that my insurance does not cover the services rendered by my doctor.

Thank you for your cooperation in this matter. We truly want to service your medical needs in the most appropriate way for you.

______________________________ ______________________

Patient/Guardian Signature Date

GALEN NORTH PEDIATRICS

MISSED APPOINTMENT POLICY

If you are unable to keep your scheduled appointment, we ask that you contact us at least 24 hours in advance. This will allow us to schedule patients that are having acute problems.

New patients that fail their original appointment without notice, or a valid reason, will not be rescheduled with Galen Medical Group NORTH PEDIATRICS

Failure to keep your appointment affects the flow of the office and creates many inconveniences to our patients. We consider a failed appointment to be: canceling on short notice, failing to arrive for an appointment, or appearing too late to be seen.

We will send out a reminder letter when you fail your first appointment. If you continue to fail two additional appointments, you will be dismissed from the practice.

If you are dismissed, we will provide emergency care for 30 days only. During this time, we recommend that you find another physician to provide your care. Upon receiving a signed release of medical information form, we will then transfer your medical records.

Thank you for your cooperation.

____
Signature of Patient

____
Date

GALEN NORTH PEDIATRICS

IMMUNIZATION POLICY

The physicians of Galen Medical Group NORTH PEDIATRICS believe in, and support the importance of immunizing children according to the American Academy of Pediatrics (AAP) immunization schedule. We recognize that deviations may occur for an individual patient due to circumstances. However, when medically appropriate, our physicians will make every attempt to catch the child up at each visit to our office. For this reason, parents who refuse to immunize their children will not be accepted into our practice.

☐ YES — I plan to immunize my child

☐ NO — I do not plan to immunize my child

______________________________ ________________
Signature of Parent/Guardian Date

______________________________ ________________
Witness Date

Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance

Insurance companies require Galen Medical Group to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

Billing Insurance

Galen Medical Group contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour's notice may be subject to a $200 fee for procedures.

Payments

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:	**To bring payment in person:**	**To Pay Online:**
Galen Medical Group	Galen Medical Group	www.galenmedical.com
P.O. Box 1030	4976 Alpha Lane	
Chattanooga, TN 37401	Hixson, TN 37343	

To make a payment by phone and/or if you have any questions regarding your statements or our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725**.

NOTE:

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

___________________________ ________

Patient Signature Date

____

Printed Patient Name