Revised 5/2017

209 W. Spring St. Suite 300
Sylacauga, AL 35150
Phone: 256-208-0060
Fax: 256-208-0755


398 Chesser Dr. Suite 7
Chelsea, AL 35043
Phone: 205-678-1286
Fax: 205-618-9696

**Patient Information:**

Child's Name: Last_____First: _____Middle: _____

Child's Birthday: _____ Child's Social Security Number: _____

Child's Sex: _____Child's Race: _____ Patient lives with:_____

Address: _____

City: _____ State: _____ Zip: _____

How would you like to be reminded of your child's appointment? **Please Rate your method 1, 2, & 3** _____ Text ____ Phone Calls ____ E-Mail

Parent/Guardian:_____

Birthdate:_____ SS#:_____

Address: ☐Check if same as patient address

_____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Circle your relation to the patient:

Mother/Father Step-parent Foster Parent Guardian

Parent/Guardian:_____

Birthdate:_____ SS#:_____

Address: ☐ Check if same as patient address

_____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Circle your relation to the patient:

Mother/Father Step-parent Foster Parent Guardian

**Siblings:** Last Name, First Name Gender Date of Birth

_____ ☐F ☐M _____

_____ ☐F ☐M _____

_____ ☐F ☐M _____

_____ ☐F ☐M _____

**Consent For Treatment**: I consent to necessary treatment, including drugs, medicine, performance of operation and conduct x-ray, or other studies that may be used by the attending physician, nurse or staff.

**Authorization For Release Of Information**: I authorize Pathway Pediatrics to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

**Assignment of Benefits**: I hereby authorized payment directly to Pathway Pediatrics of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Pathway Pediatrics charges for the services. I understand that I am financially responsible to Pathway Pediatrics for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage are subject to coordination of benefits.

**Guarantee of Account**: For services furnished by Pathway Pediatrics I hereby guarantee the payment of all accounts for services rendered**. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney's fee and a collection fee of 50% of the balance due.**

Signature: _____Date: _____

# Insurance Information

Person responsible for account: _____ D.O.B _____

Social Security Number: _____Relationship: _____

**PRIMARY** Insurance Company: _____

Policy holder's name: _____

Relationship to the patient: _____

Person responsible for account: _____ D.O.B _____

Social Security Number: _____Relationship: _____

**SECONDARY** Insurance Company: _____

Policy holder's name: _____

Relationship to the patient: _____

# Communication Authorization Form

Patient Name: _____DOB: _____

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other persons with whom we can discuss you/your child's care and share protected health information to.

**Please list below any people with whom you authorize our office to discuss aspects related to your child's care.**

Name: _____ Phone number: _____ Relationship to patient: _____

Name: _____ Phone number: _____ Relationship to patient: _____

Name: _____ Phone number: _____ Relationship to patient: _____

Name: _____ Phone number: _____ Relationship to patient: _____

**I have received a copy of the Privacy Practices from Pathway Pediatrics: Yes _____ No_____ Declined copy_____**

Patient Signature: _____ Date: _____

# Electronic Prescription Form

I, _____, whose signature appears below, authorize Pathway Pediatrics, Inc. Providers to view the external prescription history via the RxHub service for the patient listed below.

**By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.**

_____I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

_____
(Patient Name)

**Preferred Pharmacy: _____ Location: _____**

**My signature certifies that I read and understand the above and that I authorize the access.**

_____ _____
(Signature of Patient/Guardian) (Date)

_____
(Guardian's Relationship to patient)

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# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

This Authorization applies to the following information:

☐ All Information/ Complete Medical Records.

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information.

☐ Only the follow records or types of Information: _____

Treatment Dates: From (___/___/___) to (___/___/___)

The Information may be release as follows:

☐ From Pathway Pediatrics, Inc.
209 W. Spring Street
Suite 300
Sylacauga, AL 35150

☐ To: _____
_____
_____

Or _____

☐ From: _____
_____
_____

☐ To: Pathway Pediatrics, Inc.
398 Chesser Dr, Suite 7
Chelsea, AL 35043
Fax: 205-618-9696

☐ To: Pathway Pediatrics, Inc
209 W Spring St, Suite 300
Sylacauga, AL 35150
Fax: 256-208-0755

**Purpose of the release**

☐ Continuity of Treatment ☐ Other (Please Specify): _____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subjected to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical records copies, please ask about the coy fee by law that may apply. I represent that I have the authority to voluntary grant permission for the information to be released as described above.

_____ _____
(Patient/Parent/Legal Guardian Printed Name) (Patient/Parent/Legal Guardian Signature) Date

_____
(Witness Signature for Patient/Parent/ Legal Guardian) Date

# Vaccine Agreement

At Pathway Pediatrics, we are dedicated to providing the best care for every child we see. Because the health of our patients is our highest priority, and because we believe in the safety and efficacy of vaccines, we require all our patients to vaccinate with required childhood immunizations. All of our providers have followed this schedule with their own children. We understand the complexity of adhering to vaccines in a timely manner and will therefore require our patients to adhere to the recommended guidelines as follows:

**At 9 months and at 18 months of age children must be up to date on all vaccines required by this age respectively.**

You will be notified if your child has not completed the routine vaccinations by 9 months and/or 18 months. You will have the opportunity to bring your child in for a well visit and/or immunization visit after notification. If you do not bring your child in for immunizations after notification, Pathway Pediatrics reserves the right to dismiss your child from its practice. It will be at the discretion of Pathway Pediatrics to dismiss patients on a case by case basis.
It is of utmost importance for the safety of your child and for other children in our practice that your child stay current with immunizations. If you have questions regarding immunizations please ask to speak with a nurse or provider.

I agree to follow the recommended guidelines for immunizations for my child and will adhere to Pathway Pediatrics policy on immunizations as outlined above:

Parent signature_____ Date:_____

Child's name_____

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# Easy Pay Agreement

**This service will allow you to pay co-pays, deductibles, and balances easily and conveniently.**

With this service you authorize Pathway Pediatrics, Inc to use this credit card as the form of payment for balances accrued, including lab test, co-pays, coinsurances, and deductibles.

**What might my card be charges for?**
Co-Pays: Co-pays are due at the time of the office visit.

Outstanding Balance: After your insurance provider has paid their portion of your bill [or any other patient you have listed on this form] if there is still an outstanding balance owed less than $50.00, we will automatically charge the credit card on file, and mail you a statement and receipt of payment. For any balance over $50.00, we will contact you for permission to charge the total amount or set-up payments with the card on file. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. If your insurance company sends us a corrected payment at a later date, reducing your responsibility, we will refund or credit your account.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire on the expiration date listed below**. The card holder may revoke this consent at any time in writing.

**Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express** ☐

Credit Card Holder's Name: _____ DOB: ___ / ___ / ____
*(Please Print)*

Last Four Digits of Account Number: _____

**Expiration Date:** _____

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: _____ DOB: ___ / ___ / ____
*(Please Print)*

Patient Full Name: _____ DOB: ___ / ___ / ____

Patient Full Name: _____ DOB: ___ / ___ / ____

Credit Card Holder's Signature: _____ Date: _____

**Frequently Asked Questions about Easy Pay Payment Agreement**

**Why the change?**
There are several reason. First, statements are wasteful or paper, postage, and staff time. Second, we need to ensure that we have a guarantee of payment on file for each patient in our practice. We wait 20 to 30 days, and sometimes longer, for payment from your insurance company. Once that is received, we need to be sure that the patient responsible balances are paid in a timely manner

**But I always pay my bills, why me?**
We have to be fair and apply the same policy to all patients. We have wonderful patients and we know that most of your pay balances. Unfortunately, this is not always the case.

**I have never had a Dr's office ask to keep my card on file**.
We realize that this is a relatively new policy for a medical office, but it is no different from leaving a credit card on file with Amazon, or iTunes, or your cell phone vendor. They only charge you when you order something or pay your monthly bill. We are doing the same thing after your insurances pays.

**How will I know how much you are going to charge me?**
For every visit, your insurances company mails an Explanation of Benefits (EOB) to you. This document shows how much your insurance paid and what you need to pay based on the benefits and the deductible of your policy.
This office receives the same information that you do along with the payment from your insurance company. We apply the payment and make any discount or adjustment per our contract with your insurance company. The balance on your account for that visit will then match the patient responsibility on your EOB. This is the amount that will be charged to your credit or debit card. A receipt will be mailed to you.

**What is a deductible?**
This is an amount of money that you must pay out of pocket every year before your insurance begins to pay. There are different deductibles for office services and hospital services. In the past few years, deductibles have been getting larger and larger.

**What if I have a really large bill?**
We are always happy to set up a payment plan. With our system, your card can automatically be charges each month. Contact our billing staff for balances over $50.00 to discuss a plan. 256-208-0060 Option 4.

**What if I need to dispute my bill?**
All you have to do is call us, if you ever have a concern about your account. Mistakes can happen and we can apply a refund directly to your card if we have a billing error. Unless you have directed monthly payments, we only charge the amount your insurance company has marked as patient responsibility as noted on your EOB.

**What if I have 2 insurance plans?**
Each plan may have a different policy benefits and deductibles. Again, we will ask that you put a credit or debit card on file just in case these plans do not cover all your services. Remember, we will not access this information until both plans have paid AND if there is any remaining patient responsible balance.

**I don't really know my insurance benefits. Can you tell me what they are?**
Unfortunately, there are SO many health plans that we are not able to know them all. We do verify that insurance plans are effective and what the status of your deductible may be, but we do not always know the exact benefits of your plan.

**How do I find out about my benefits?**
It is important now more than ever that you know your health insurance plan.
Here are 2 ways to do it:

1. Review your plan benefits with your insurance agent
2. If your plan comes from your job, you can review benefits with your Human Resource Department
3. Call Customer Service at your insurance company. The phone number is usually on the back of your insurance card.

**Questions:** Call our Billing Specialists, Monday through Friday from 8:00am to 4:00 pm at 256-208-0060 (Option 4)

# Getting Started with the **Patient Portal**

## To Sign-up for Patient Portal:


1. Get your account information from the staff.
   **Email Log in:**_____
   **Temporary Password:**_____
2. Visit: **pathwaypeds.patientmedrecords.com**
3. Click "Log-In To Your Account"
4. Start using the portal!

### By registering today, you will be able to:

- Easily communicate with our providers and staff
- Access your child's secure health records anytime from any device
- Make online payments
- Request an appointment
- Request prescription refills and access to lab results online

Pathway PEDIATRICS

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