Madison Ridgeland Children's Clinic
401 Baptist Drive, Ste. 101
Madison, MS 39110
(601) 856-2598 • Fax: (601) 856-4459

DATE:_____ Patient Acct #:_____

PATIENT REGISTRATION

PATIENT'S NAME_____ PATIENT SS #_____

NAME PATIENT GOES BY_____

DATE OF BIRTH_____ SEX M / F REFERRED BY:_____

PARENT/GUARDIAN'S NAME:_____ HOME TEL. NO._____

ADDRESS_____
(STREET) (CITY, STATE, ZIP)

MOTHER'S NAME:	FATHER'S NAME:
MOTHER'S EMPLOYER	FATHER'S EMPLOYER
WORK ADDRESS	WORK ADDRESS
WORK TEL. NO. CELL TEL. NO.	WORK TEL. NO. CELL TEL. NO.
MOTHER'S SOCIAL SEC NO.	FATHER'S SOCIAL SEC NO.
MOTHER'S DATE OF BIRTH	FATHER'S DATE OF BIRTH

EMERGENCY CONTACT (OTHER THAN IMMEDIATE FAMILY)

NAME:_____ TELEPHONE:_____

ADDRESS:_____

INSURANCE & BILLING INFO

MEDICAL COVERAGE EFFECTIVE DATE_____

(1) PRIMARY_____ GROUP# ID#_____

Address: _____ Insured's Name:_____

(2) SECONDARY_____ GROUP# ID#_____

Address:_____ Insured's Name:_____

**If you have more than one medical insurance, the primary is based on which insured's birthday comes first in the year.

CHILD'S SIBLING'S AGE SEX HEALTH

_____
_____
_____
_____
_____
_____
_____
_____

Please List Child's:

Medicine Allergies_____

Food Allergies_____

Surgeries_____

Hospitalizations_____

Serious Illnesses_____

Chronic Family Illnesses_____

PLEASE COMPLETE BACK OF FORM

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Madison-Ridgeland Children's Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Madison-Ridgeland Children's Clinic for services rendered in my medical care. If the assignment is accepted, I understand that I am financially responsible for any balances not covered by my insurance. **Co-pays are due at time of service.**

A photocopy of these assignments shall be valid as the original.

_____ _____

Patient (please print) Date

_____ _____

CONSENT TO TREAT

I_____, do give Dr. Leslie L. Jones / Dr. Leslie B. Delaney / Dr. William D. Payne / Dr. James H. Stewart and their staff my permission to administer medical treatment to

_____

(Name of Patient)

Signed:_____ Date:_____

_____

(Relationship to patient)

Witness:_____ Date:_____

Madison-Ridgeland Children's Clinic
401 Baptist Drive, Suite 101
Madison, MS 39110
Phone (601) 856-2598 Fax (601) 856-4459

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of the Madison-Ridgeland Children's Clinic to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health information will not be disclosed except in those situations described in the Notice of Privacy for Madison-Ridgeland Children's Clinic.

Name and relationship of the person you wish to allow access to your health information. For example: your parents, spouse, sibling, grandparents, neighbor, caretaker, or close friend:

Name (Including Parents) **Relationship to Patient**

_____

_____

_____

_____

_____

_____

This authorization to use and disclose protected health information is being submitted by my request and shall be in force and effect until revoked by me in writing. I understand that I have the right to revoke this authorization at any time by sending written notification to Madison-Ridgeland Children's Clinic. I understand that information used or disclosed pursuant to this authorization may be disclosed by the Madison-Ridgeland Children's clinic and may no longer be protected by Federal or State law.

_____ _____

Signature of Parent, Guardian, or Representative Date

MADISON-RIDGELAND CHILDREN'S CLINIC PA'S NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We will:

- keep medical information about you private, as provided by law;
- provide, or make available, as applicable, this notice of our legal duties and privacy practices with respect to medical information about you;
- notify affected individuals following a breach of unsecured protected health information; and
- follow the terms of the notice that are currently in effect.

How we may use and disclose medical information about you

We will share medical information about you for purposes of treatment (such as sending medical information about you to your physician or to a specialist as part of a referral); to obtain payment for treatment (such as submitting information that identifies you and your diagnosis to a payer or Medicare); and to support health care operations (such as using information about you to assess the quality of care we have provided, utilization and patient satisfaction review).

We may use health information about you without your prior authorization for several other reasons. Subject to applicable law, we may give out medical information about you to other entities to carry out their duties for (a) public health purposes (such as births, deaths, public health surveillance); (b) abuse, neglect or domestic violence reporting; (c) health oversight audits or inspections; (d) research studies; (e) coroners or medical examiner services; (f) funeral arrangements; (g) organ donation; (h) tracking of FDA-regulated products; (i) workers' compensation purposes; and (j) emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may contact you to support fundraising efforts and you have the ability to opt out of receiving such communications. We may disclose medical information about you to a friend or family member who is involved in your medical care, to others whom you designate as involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

Before we make any use or disclosure of your protected health information for marketing purposes, any disclosure that constitutes a sale of your protected health information, or in any other situation not covered by this notice where we may wish to use or disclose medical information about you, we will ask for your written authorization. You can later revoke your authorization by notifying us in writing.

Your rights regarding medical information about you

In most cases, when you submit a written request, you have the right to look at or get a copy of medical information that we use to make decisions about your care. We will provide you a form that you can complete to make the request. If you request copies of the information, however, we may charge a fee for cost of copying, mailing or other

related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in our records about you is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing and including your reason for requesting the amendment. We will provide you a form that you can complete to make the request. We may deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine the record is complete and accurate. If we deny your request to amend, you may submit a written request to review that denial. You have the right to make a written request to us for a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure. Your request must state the time period desired for the accounting, which must be less than a 6-year period starting after April 14, 2003. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before charging you.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to communicate with you.

You have the right to restrict us from disclosing medical information about you to a health plan when you pay out of pocket in full for the health care item or service.
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but our processes may not be able to accommodate it and we are not legally required to agree to your request. We will inform you of our decision on your request.

All written requests or requests for review of denials should be submitted to our Privacy Officer identified at the bottom of this notice.

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (listed below), or you may send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. Our Facility Privacy Officer can provide you the address. Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer: Kathy Peace
401 Baptist Drive
Madison, MS 39110
601-856-2598

Madison-Ridgeland Children's Clinic PA
401 Baptist Drive
Madison, Mississippi 39110
601-856-2598

Version effective November 7, 2014

Facility: Madison – Ridgeland Children's Clinic PA
Address: 401 Baptist Drive, Suite 101
Privacy Official: Kathy Peace
Telephone: 601-856-2598 Fax: 601-856-4459

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Facility named at the top of this page. I understand further that the Medical Facility and its business associates (including its billing company) may use or disclose my health information in communications with third parties who are involved in or indicate that they are responsible for payment for my healthcare services. I understand that such third parties might include persons who are policy holders of any policy of insurance covering me. I acknowledge that I am entitled to prevent these communications by objecting to them, and by signature below, indicate that I DO NOT OBJECT to such communications.

Print Name of Patient: _____ Date: ____/____/_____

Patient's Date of Birth: ____/____/_____ Patient's ID/Chart Number: _____

_____

SIGNATURE OF PATIENT

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____ Date: ____/____/_____

Relationship of Representative (parent, guardian, etc) _____

_____

_____

_____

SIGNATURE OF PERSONAL REPRESENTATIVE

OPTIONAL DESIGNATION OF PERSONS TO WHOM WE MAY DISCLOSE YOUR RECORDS IN YOUR ABSENCE:

1. _____
2. _____

(You may also call us or personally inform us at any time of persons to whom we may disclose your records.)

For Facility Use Only:

_____

_____

_____

_____

Signature of Facility Employee Date

MADISON - RIDGELAND CHILDREN'S CLINIC

LESLIE L. JONES, M.D.
WILLIAM D. PAYNE, M.D.

401 BAPTIST DRIVE, SUITE 101
MADISON, MISSISSIPPI 39110
(601) 856-2598 • Fax: (601) 856-4459

LESLIE DELANEY, M.D.
JAMES H. STEWART, M.D.

Madison-Ridgeland Children's Clinic Payment Policy

We try to provide you with the highest quality medical care available. We also realize that medical costs are of concern to you. Our staff works very hard to keep down expenses by keeping down costs. We've developed the following guidelines to help.

We are contracted with the following insurance companies: Blue Cross & Blue Shield (Federal, Regular, and State) MS Health Partners, MS Physician Care Network, United Healthcare, United Healthcare Chips, First Health, Tricare (Prime and Standard), and Aetna. We will file your claims for you. You will be expected to pay your copay at the time of service. All insured patients will be expected to pay the network charges per our contract rates with the insurance company. **For all other insurance companies with which we are not contracted, you will be expected to pay for all charges at the time of service with the exception of hospital charges. We accept cash, check, Visa, MasterCard, American Express, and Discover. You will be provided a claim form to file for reimbursement to you.** Please note that your insurance is a contract between you and your carrier, and very few insurance companies cover all medical expenses. It is your responsibility to know your policy benefits.

Hospital Inpatient Charges- We do file insurance for all hospital inpatient charges. If you do not have insurance, please contact our billing office for a payment plan. We realize that sometimes hospital admission is an unexpected cost and we are more than willing to help you make payment arrangements.

Returned Checks- Checks that are returned due to non-sufficient funds will be required to pay the amount in full along with a $40.00 service charge. We realize that sometimes this may be an oversight and if you are aware, please contact our office to assist us in arrangements for payment. We will accept only cash, money order, or certified check at this point. Unless this amount is paid within the time specified, MRCC may turn over the check to the proper authorities for collection. If this happens, the patient will be held responsible for any and all court costs.

Minor Patients- In special situations, **such as divorced parents,** whichever parent brings the child in for treatment is the one responsible for the bill.

Failure to make payment in full or on a scheduled payment date will be considered default and could cause referral for additional collection efforts. Depending on the circumstances, we may use a third party collection agency or litigation or both.

I hereby understand the payment policy of MRCC and agree to the above policy. I hereby agree to be responsible for payment of my account. If not paid when due, I will be responsible for all collection fees, interest accrued, and/or attorney fees. I do understand that if MRCC does not have a contract with my insurance company, I am responsible for all charges, and I will be expected to pay in full for services rendered.

Date: _____ Signature: _____

I hereby authorize MRCC and their doctors to release any information regarding services rendered by him/her or the corporation employees and to allow a photocopy of my signature to be used to file insurance. I authorize and direct my insurer to issue payment for services rendered by the doctors to be made directly to MRCC or the doctor. Regardless of my insurance benefits, I understand and accept responsibility for any unpaid balances.

Date: _____ Signature: _____