HEALTH ONE, INC. – Patient Information Form

Child's Name: _____ Male / Female Date: _____

Date of Birth: _____/ _____ / _____ Custodial Parent (if separated or divorced): _____

Address: _____

Parent Information:

Mothers Name: _____ DOB _____/_____/_____ SSN _____/_____/_____

Father's Name: _____ DOB _____/_____/_____ SSN _____/_____/_____

Phone: Primary ( ) _____-_____ Secondary ( )_____-_____ E-Mail: _____

Emergency Contact:

Contact Name: _____Relationship: _____Phone: _____

Statement and Payments:

Address for Billing Statement if different than above: _____

********** INSURANCE INFORMATION **********

A **copy of your insurance card** is required now and will be taken **AT EACH VISIT** so that we are able to bill your insurance company appropriately. We bill most insurance companies for you if proper information is provided us at the time of each service. Co-payments, deductible and proof of insurance coverage **(your insurance card at every visit)** are due at the time of service. Since your agreement with your insurance company is private, we do not routinely investigate why an insurance company did not pay, denied or paid less than expected for care. **If you have a question regarding how your insurance company paid your claim,** you will need to contact them at the telephone number listed on your id card. If an insurance carrier has not paid. Professional fees due will be transferred to the patient responsibility and will be due and payable in full from you.

Primary Insurance:

Carrier Name: _____ID/Cert # _____ Eff. Date: _____/_____/_____

Secondary Insurance:

Carrier Name: _____ID/Cert #_____ Eff. Date: _____/_____/_____

Primary Pharmacy: _____

(Address & Phone Number)

********** OFFICE GUIDELINES AND FINANCIAL POLICY **********

BASIC POLICY: Payment for services is due in full at the time service is provided in our office.

SHARED PARENTING: Any shared parenting arrangement, custody issues or divorce, requires that the Shared Parenting agreement be completed and signed by both parties.

COORDINATION OF BENEFITS "COB" : Is required to be verified by you, with your insurance **every January** for the new year! **If this is not done we will not be able to schedule**.

NEW BABIES – Because your insurance typically allows 30 days after birth to enroll, we will ask to have a credit card on file in case adding this dependent doesn't take place.

INSURANCE CARD: All patients must provide a current, valid proof of eligibility ID insurance card, **upon each visit** before being seen. **This must be presented at every appointment – No exceptions**, or the professional fees must be paid at the time of service, or credit card left on file with authorization to charge for that visit. Any future insurance payment would of course be refunded to the patient/responsible party.

NONCOVERED SERVICES: Any Care not paid for by your insurance carrier will require payment in full at the time services are provided or within 30 days of notice of insurance claim denial. If any such balance carries over to the next visit, this balance will need to be paid before the appointment takes place.

PERSONAL INJURY CASES: **This office does not bill for auto accident or other liability or lawsuit-related cases.** You are responsible for payment at the time of service. We do not accept liens. The first care rendered after an auto accident should be in an emergency room.

YEARLY HEALTH CHECKS: Our office and most likely your insurance company, requires that ALL patients have a **yearly physical** in order to evaluate and coordinate the overall health and welfare of our patients. Failure to adhere to this policy can prevent necessary care, delay prescription refills and may result in dismissal from our practice.

WELL WITH A PROBLEM – Will cause a well visit to incur any applicable copays, deductible or Coinsurance out of pocket expense.

PARENTAL ATTENDANCE: Patients under the age of 18 may be seen for *sick visits* without a parent/guardian present if consent to do so is on file. Patients under the age of 18 who are scheduled for a well or mental health visit MUST have a parent/guardian present at the time of the appointment.

LATE / MISSED APPOINTMENTS: In fairness to the other patients and to our providers, we require at least 24 hours notice to cancel appointment. A fee will be assessed to ALL missed appointments. Patients who miss 3 or more appointments without proper notice may be dismissed from the practice. We reserve the right to reschedule any patients that arrive for their appointment more than **10 minutes after their scheduled appointment** time. ***Arrive 15 minutes early if there is new insurance to discuss, prior balances to be paid or any other administrative issue that needs attended to.***

COLLECTION POLICY: We make every effort to contact and work with patients who have an outstanding balance prior to turning the account over to an outside collection agency. Once your account is turned over to collections, we will no longer treat your child and patient records must be transferred to another physician.

**********Please visit our website at www.HealthOneOhio.com for additional guidelines and policies.**********

********** ASSIGNMENT OF BENEFITS **********

I hereby authorize direct payment of benefits to Health One, Inc. for services rendered by him/her in person or under his/her supervision. I understand that financially I am responsible for any balance not covered by my insurance. I hereby authorize Health One, Inc. to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefits, within the limits of HIPPA regulations. A photocopy of these assignments shall be valid as original. **By signing below we acknowledge that we have read and understand Health One's HIPPA and Office Policies disclosed on Healthoneohio.com and agree to these policy guidelines.**

Parent's Signature:

_____ Printed Name: _____

Patient:_____ Sibling:_____

Sibling: _____ Sibling: _____