Ballentine Pediatrics Demographic Questionnaire

PLEASE COMPLETE ALL SECTIONS BELOW

Patient Information

Patient's Full Name _____ Date of Birth ____/____/_____
First Middle Last

Address _____ Apt/Lot #_____ City _____ Zip _____

Home Phone # _____ Patient's SS# _____-_____-_____ Male or Female

Preferred Language_____ Ethnicity: Hispanic/Latino (circle one) Yes or No

Race: _____ African American/Black _____ American Indian/Alaskan Native _____ White

_____Other Race (please specify) _____

Parent Information

Father's Name _____ Date of Birth ____/____/____ SS# ____-____-_____

Employer _____ Work #_____ Cell #_____

Mother's Name _____ Date of Birth: ____/____/____ SS# ____-____-_____

Employer _____ Work #_____ Cell #_____

Insurance Information

Primary Insurance _____ Effective Date ____/____/____ ID_____

Policy-Holder's Name: _____ Date of Birth: ____/____/____ Relationship to patient_____

Employer _____ Group #_____

Secondary Insurance _____ Effective Date ____/____/____ ID_____

Policy-Holder's Name: _____ Date of Birth: ____/____/____ Relationship to patient_____

Employer_____ Group #_____

Responsible Party Information

Responsible Party Name _____ Relationship to Patient _____

Address _____ Apt/Lot #_____ City _____ Zip _____

Home # _____ Work # _____ Cell # _____

Sibling Information (Brothers and Sisters) *If additional space is needed continue on the back of page.*

First Name	Last Name	Date of birth	Sex

I hereby assign all medical and surgical benefits to which I am entitled and authorize and direct my insurance carrier to issue payment directly to BALLENTINE PEDIATRICS, LLC for services rendered. I hereby authorize the release of any medical information necessary to process insurance claims. I understand that I am responsible for any amount not covered by insurance.

Signature Relationship to Patient Date

Thank you for allowing us to be a partner in your children's healthcare.

Ballentine Pediatrics, LLC

11134 Broad River Road Suite D Irmo, SC 29063
Office 803-732-0920 Fax 803-227-2759

Rights, Responsibilities and Financial Obligations

Patient Name_____ **D.O.B.**_____

- South Carolina laws require that an adult be present for medical treatment of any person under the age of 16 years. If an adult is not present, the appointment may be rescheduled.
- I have the right to be seen in a timely manner and have the right to reschedule my appointment if delays are too lengthy.
- I agree to be on time for my appointments and understand that if I am more than 15 minutes late for my appointment I may be asked to reschedule the appointment.
- I understand that I must give a 24 hour notice for appointment cancellations or to re-schedule an appointment and understand that if I fail to do so, the appointment may be considered a missed appointment and I may be charged a fee.
- I agree to be financially responsible for a $25.00 fee for each missed appointment and understand that this fee must be paid in full within 30 days.
- I understand that if my family has 3 or more missed appointments within a 12 month period, my family may be dismissed from the practice.
- I understand that school excuses can only be given if my child has been seen by a provider at Ballentine Pediatrics or if I have contacted the office and spoke with a member of the nursing staff on the day that my child was home sick.
- I understand that a 24-72 hour notice is required for the completion of all forms, letters or statements and that there may be a fee between $2-$20 per page and that this fee must be paid in full before the document(s) can be released.
- I understand that there is a fee for obtaining copies of my medical records and that this fee must be paid in full before records will be released and that I will not be charged more than state laws permit.
- I understand that I will be charged a $35.00 fee for any returned check and all future payments will be required to be paid in the form of cash, or credit/debit card.
- I understand that the physicians can only bill for the procedures and diagnosis documented in the patient's medical records and to ask the physician to change a diagnosis to secure insurance payment constitutes as fraud.
- I agree that I will be financially responsible for a $20.00 fee for each phone call made after normal business hours that require the assistance of a nurse or physician and that this fee must be paid in full within 30 days.
- I understand that I will be financially responsible for an additional $30.00 fee for weekend appointments, any appointment outside of normal business hours, or any appointment that disrupts other scheduled appointments including walk-ins, and emergency visits.
- I understand that I must present current valid insurance information at the time of service. If proper insurance information is not available at the time of service I will be considered a self-pay patient and will be required to pay in full at the time of service.
- I understand that I have 30 days from the date of service to present proper insurance information and to dispute any balances due. If insurance information is not presented within 30 days from the date of service I may be asked to pay the account balance in full and may be required to file insurance claims for these services myself.
- I understand that Demographic, Consent, and Contact changes must be submitted in writing within 30 days.
- I understand that it is my responsibility to know the benefits of my insurance plan and to contact my insurance carrier or the benefits coordinator at my place of employment to determine if a service is covered or not.
- I understand that I am responsible for obtaining all necessary referrals from my insurance carrier(s) for services being rendered or ordered.
- I understand that Ballentine Pediatrics provides medical services in accordance with the guidelines approved by the American Academy of Pediatrics and agree to be financially responsible for all medical services not be covered by insurance.
- I understand that payment is due at the time of service and I may be asked to reschedule my appointment if I am not prepared to pay at the time services are rendered. (Cash, Checks, Visa, Master Card, and Discover are accepted forms of payment.)
- I understand that all co-pays are due at the time of service and that I may be billed a $10.00 convenience fee if I do not pay my co-pay at the time of service.
- Any balances older than 90 days past due will be subject to a $5.00 monthly statement fee.
- I will be responsible for any costs incurred if my account is turned over to a collection agency which may include collection agency fees up to 35% of the outstanding balance, court costs, and attorney fees.

By signing below I am acknowledging that I have read and agree to the above information. I have had the opportunity to ask any questions and agree to meet all responsibilities and obligations.

_____ _____ _____

Signature **Relationship to Patient** **Date**

Ballentine Pediatrics, LLC
11134 Broad River Road Suite D Irmo, SC 29063
Office 803-732-0920 Fax 803-227-2759

Medical Consent and Information Release

I, _____ (Parent or Legal Guardian) hereby agree that the Providers of Ballentine Pediatrics will provide medical care for my child/children listed below:

Name	DOB	Name	DOB

Please list all individuals (other than parents or legal guardians) who you have given authorization to bring the above listed child(ren) in for medical treatment, or to pick up prescriptions, receive lab results and or medical information pertaining to treatment or care, schedule and obtain appointment information, give and receive insurance and account information.

Name	Relationship to Patient	Phone/Contact Information

I hereby authorize Ballentine Pediatrics to: (1) release any information necessary to insurance carriers regarding the above listed child(ren)'s illnesses and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Name	**Relationship to Patient(s)**	**Date**

Ballentine Pediatrics, LLC
11134 Broad River Road Suite D Irmo, SC 29063
Office 803-732-0920 Fax 803-227-2759

Notice of Privacy Practices Disclosure

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

Patient Name_____ **D.O.B.**_____

I hereby acknowledge that I have been given the opportunity to review the Notice of Privacy Practices at Ballentine Pediatrics. I understand that I may obtain a copy of the Notice of Privacy Practices at any time, upon request.

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

By signing below I am acknowledging that I have read and understand the above information. I have had the opportunity to read the Notice of Privacy Practices and to ask any questions.

_____

Signature **Relationship to Patient** **Date**

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE

- ☐ Friend/Referral
- ☐ Internet/Google
- ☐ Yellow Pages Phone Book
- ☐ Yellow Pages Online
- ☐ Other(describe) _____

PHI Consent Form

Child's Name **Date of Birth**

Emergency Contact:_____Relationship_____Phone#_____

Preferred Pharmacy (**Include location**): _____

Preferred Phone# for Messages and Appointment Reminders: (_____)_____

Preferred Email: _____ Mother____ Father____ Other_____

Secondary Email: _____ Mother____ Father____ Other_____

Patient Portal: Ballentine Pediatrics offers a patient portal that allows you access to your child's medical information. Would you like access to this information? YES_____ NO_____

Consent for Disclosing Protected Health Information

I, _____ authorize Ballentine Pediatrics to disclose the following "Protected Health Information": Doctor's Excuse_____ Immunization Record_____ Permission for Medication____ for my child listed above.

I understand that there is an increased risk for an unauthorized person to receive my "Protected Health Information. Please select the method(s) that you authorize Ballentine Pediatrics to share your child's information upon your verbal request.

School/Daycare: Name_____Fax_____ **(initial)** ___

School/Daycare Location:_____

Work or Personal Email: _____ **(initial)** ___

Work or Personal Fax:_____ **(initial)** ___

Print Name of Parent/Guardian Relationship

Signature Date