# Must be filled out completely and legibly in order for claims to be submitted to your insurance!

**Patient Name:** (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Sex: M F Social Security Number _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

**Father's Name:** (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

**Mother's Name:** (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

**Siblings:** (First name, last name, and age)

_____ _____

_____ _____

**Emergency Contact other than parent:**

Name: _____ Phone: _____ Relationship: _____

In the absence of the parents/guardians, what other adults (18 and older) are permitted to accompany your child to our office?

_____

If parents/guardians are unavailable, with whom may we leave a message at your home? _____

How may we leave messages regarding appointments, lab/x-ray reports? Answering Machine _____ Voice Mail _____ Other _____

Preferred contact number during the day: _____

How did you hear about us? _____

# University Hospitals Medical Practices

(Rev 8/12)

**Note: Adult Children, aged 18 years and over, will need to sign their own Financial Policy as required by Law.**

| | Date of Birth | Sex | Social Security Number |
|---|---|---|---|
| **Patient Legal Name**_____ | __/__/__ | **M or F** | **SS#**_____ |

**List best contact phone number for Dependent(s): (_____) _____-_____**

***List the Name of the Residential and Custodial Parent for above Minor children on this Line***_____

FINANCIAL AND MANAGED CARE POLICY STATEMENT

University Primary Care Practices adheres to the policies below. The patient / responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

1. Patients with an insurance co-payment are expected to make payment when checking in for the appointment.
2. Patients with high deductible ($1000 or more) plans are required to pay the following fees prior to their doctor visit: $100.00 for first new patient visit, $50.00 for each subsequent visit, $100.00 for consultations, $50 for urgent care visits. Patients will be refunded or billed for additional amounts as appropriate after claim(s) are processed by their insurance company.
3. Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
4. Not all services are covered benefits of all insurance plans. The patient / responsible party maintains the responsibility of verification of applicable coverage.
5. The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at time of service.
6. Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.
7. UHMSO does not bill third parties in legal situations or injuries (non work related). We bill your health insurance. Any balance unpaid by your health insurance will be billed to the guarantor on the patient account.

We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). Returned checks and balances older than 45 days may be subject to additional collection fees. We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today's appointment. Thank you for your understanding and cooperation with this policy.

1. **I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.**
2. **I agree that this authorization is valid regardless of when I receive services at this office, that the information on pages above is accurate, and that I am the patient or authorized to sign this document.**

**X Guarantor/Responsible Party Signature:**_____ **Date:**_____

**Date of Birth:**_____ **SSN:**_____ **Telephone#:**_____

## GENERAL CONSENT

### GENERAL CONSENT-SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

**Authorization for Treatment**

[Patient/Patient's legal representative] agree to permit authorized personnel of University Hospitals [the Hospital] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I further understand that the Hospital is a teaching institution and that physicians, nurses and other healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may used for educational purposes.

**I recognize and understand that the physicians, including, but not limited to emergency department physicians, who provide services at the Hospital, with the exception of residents, are independent practitioners and not employees or agents of the Hospital. The Hospital is not responsible for the acts or omissions of physicians who are not directly controlled by the Hospital.**

**Authorization to Release Information**

The undersigned hereby permits University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in healthcare and/or the Hospital's agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, training or educating students, performance improvement initiatives, discharge planning, risk management and/or as required by law. The undersigned hereby permits its affiliated healthcare providers and/or their authorized personnel to access electronic prescription data.

**Assignment of Benefits**

In consideration of the Hospital's and/or physician(s)'s services received or to be received for medical/surgical services, I assign to the Hospital and/or my physician(s), all benefits herein specified, not to exceed the above hospital/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Hospital and /or my physician(s). I hereby agree to pay any and all hospital and/or physician(s) fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment.

**Medicare/TRICARE/Champus Payment /Notice of Privacy Practices**

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**Record Retention Policy**

The Hospital retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

**Computer Data**

I understand that my medical records will be accessible to authorized Hospital personnel through computers and that the Hospital will comply with certain safeguards established by federal state and local law as well as Hospital policy.

**Certification**

I certify that to the best of my knowledge and belief the information provided is complete and correct. In understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on the form. Otherwise, subject to applicable law, this consent will expire at the same time the Hospital's record retention period for this document expires.

**Patient Personal Property/Payment for Non-Reimbursable Items**

I understand that the Hospital is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe. I understand and agree to pay the charges incurred by me or on my behalf for personal use and/or convenience items and hereby authorize the hospital to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same.

**Other Uses of Medical Information**

The undersigned hereby understands and recognizes that University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel have access to medical information which may be used by UH and its research personnel for research related purposes. The use of medical information for research related purposes is subject to Federal and State laws and regulations, as well as Hospital policies regarding research studies.

**Additional Permitted Uses and Disclosures of Confidential Medical Information**

The undersigned understands and consents to disclosure of confidential medical information to a State or Federal Health Oversight Agency; an appropriate Public Health Authority; for purposes required by State and/or Federal Law; in cooperation with a Law Enforcement Investigation; in cooperation with a domestic or child abuse investigation; to organ procurement organizations; and for any other permissible purpose as outlined in University Hospitals Notice of Privacy Practices.

**Notice of Privacy Practices - Acknowledgment**

☒ **PLEASE CHECK THE APPROPRIATE BOX:**

☐Yes ☐No ☐N/A I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP").

If no, reason acknowledgement of NOPP not received:_____

**I AM THE GUARANTOR/RESPONSIBLE PARTY OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.**

**Signature of Guarantor / Responsible Party: ****

☒_____Date:_____Relationship:_____

Witness:_____Date:_____

**** OR, Signature of Legal Representative, if Guarantor/Responsible Party is unavailable:**

_____Date:_____

# Insurance Coverage

This information must be complete, otherwise you will be billed, not the insurance company. If there is incomplete or incorrect insurance information provided, this account will be considered self-pay.

Signature _____ Date _____

PATIENT NAME: _____ DATE OF BIRTH: _____

## Primary Insurance

Name of Insurance Company: _____

Insurance ID#: _____

Policyholder: _____

Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____

Employer: _____

Employer Address: _____

_____

Employer Phone: _____

## Secondary Insurance (if applicable)

Name of Insurance Company: _____

Insurance ID#: _____

Policyholder: _____

Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____

Employer: _____

Employer Address: _____

_____

Employer Phone: _____

University Hospitals
Rainbow Babies & Children's Hospital

Medina Pediatrics

Martha Myers, MD
Laurel Roach-Armao, MD
Stacey Memberg, MD
Douglas Fall, MD
Barb Steiner, PNP-BC

# MEDINA PEDIATRICS - PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

**Please complete this section ONLY if you give permission as a parent/legal guardian for the following minor child, _____ date of birth _____, to be accompanied by the individuals listed below to office visits and to treatments requiring only general consent; I have already signed the general consent form.**

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

**Please complete this section <u>ONLY</u> if you consent for your minor child to transport himself/herself alone to office visits and treatment that require only general consent.**

My minor child _____, date of birth _____ has my permission to transport himself/herself to receive general treatment that requires only general consent which I, as parent/legal guardian, have already given to Medina Pediatrics.

THIS SECTION MUST BE COMPLETED BY THE PARENT/LEGAL GUARDIAN:

I understand that the above permission is in place until revoked by me and/or the expiration of one year.

_____ _____ _____
Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Relationship to child

_____
Date

You can contact me by phone if needed at:

_____ _____ _____
Home Cell Work



4001 Carrick Dr #160
Medina, OH 44256
330-723-7005 Phone
330-723-4854 Fax

Name: _____ Birthdate: _____

# PATIENT HISTORY

Mother's Name: _____ Father's Name: _____

Mother's DOB: _____ Father's DOB: _____

Mother's Occupation: _____ Father's Occupation: _____

Sibling: _____ Birthdate: _____

Sibling: _____ Birthdate: _____

Sibling: _____ Birthdate: _____

Who lives at home? _____

Pets in the home? _____

**Circle YES or NO :**

| | | |
|---|---|---|
| Well water? | Y | N |
| Smokers in home? | Y | N |
| Guns in home? | Y | N |
| House built before 1960? | Y | N |
| Smoke detectors in home? | Y | N |

## PAST MEDICAL HISTORY

Birth weight: _____ Length: _____

Days spent in hospital? _____

Breast or Formula fed: _____

Past medical problems: _____

Hospitalization: _____

Surgeries: _____

Known drug allergies: _____

**Family History– Please check "M" for mom, "D" for dad, "S" for siblings and "GP" for grandparents if known:**

| Illness or Disease | M | D | S | GP | Illness or Disease | M | D | S | GP |
|---|---|---|---|---|---|---|---|---|---|
| Allergies | | | | | Kidney Disease | | | | |
| Anemia | | | | | Irritable Bowel | | | | |
| Asthma | | | | | Learning Disability | | | | |
| Attention Deficit | | | | | Mental Illness | | | | |
| Bleeding Problems | | | | | Migraine | | | | |
| Blood Clot | | | | | Multiple Sclerosis | | | | |
| Cancer | | | | | Scoliosis | | | | |
| Cardiomyopathy | | | | | Seizures | | | | |
| Celiac Disease | | | | | Eczema | | | | |
| Crohn's Disease | | | | | Substance Abuse | | | | |
| Diabetes-Juvenile onset (Type 1) | | | | | Sudden Cardiac Death | | | | |
| Diabetes– Adult onset (Type 2) | | | | | Sudden Infant Death | | | | |
| Heart attack before 55 | | | | | Hypothyroid | | | | |
| High Blood Pressure | | | | | Ulcerative Colitis | | | | |
| High Cholesterol | | | | | Other: (Please Specify) | | | | |