

**LITTLE ROCK CHILDREN'S CLINIC, P.A.
PATIENT REGISTRATION – OVER 18 YEARS**

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	NAME CALLED	D.O.B.	M or F	SOCIAL SECURITY NUMBER
ADDRESS			RACE: WHITE AFRICAN AMERICAN NATIVE HAWIIAN/ OTHER PACIFIC ISLANDER NATIVE AMERICAN INDIAN/ALASKAN OTHER RACE: _____	ETHNICITY (ORIGIN): NOT HISPANIC or LATINO HISPANIC or LATINO		PREFERRED (PRIMARY) LANGUAGE
CITY, STATE, ZIP			CONTACT PHONE NUMBER		CONTACT METHOD: TEXT	PHONE CALL
E-MAIL ADDRESS			EMPLOYER/SCHOOL		PHONE	ADDRESS
NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU			PHONE		ADDRESS	CITY, STATE, ZIP

PARENT INFORMATION

MOTHER'S NAME	FATHER'S NAME
FIRST MIDDLE LAST	FIRST MIDDLE LAST
D.O.B. SS#	D.O.B. SS#
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
EMPLOYER WORK #	EMPLOYER WORK #
HOME PHONE PAGER	HOME PHONE PAGER
CELL PHONE EMAIL	CELL PHONE EMAIL

INSURANCE INFORMATION

PLEASE PRESENT CARD TO THE RECEPTIONIST

PRIMARY INSURANCE NAME:	SECONDARY INSURANCE NAME
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
POLICY #: GROUP #:	POLICY #: GROUP #:

CONSENT TO RELEASE MEDICAL INFORMATION

May we disclose the following to the PARENT/GUARDIAN listed above either by phone or in person? YES NO If YES, please check what we may disclose.

LAB RESULTS
 X-RAY RESULTS
 IMMUNIZATION RECORD
 ENTIRE MEDICAL RECORD
 BILLING QUESTIONS

OTHER: _____

I understand and agree this Consent to Release Medical Information will remain in effect until it is revoked by me by delivered written notice of such revocation to Little Rock Children's Clinic, P.A.

Date: _____ Signature: _____

PLEASE READ AND SIGN

Medical/Research Consent: I authorize all physicians providing services at Little Rock Children's Clinic, P.A. to render any medical treatment deemed necessary for my care.

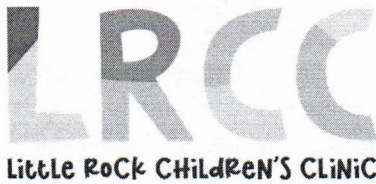
Insurance/Financial: Insurance regulations state that if a co-pay is part of your policy, it must be paid at the time of service. I understand that I am responsible for any amount not covered by insurance. Also, in the event of non-payment of my accounts, I understand that I am responsible for all collection costs, including, but not limited to court costs and attorney fees. Little Rock Children's Clinic, P.A. will receive 100% of all charges owed if the account is placed for collections. I also agree that proper jurisdiction and venue will be in Pulaski County, Arkansas.

Insurance Authorization and Assignment: I hereby authorize the release of any medical or other information necessary to process medical insurance claims. I also request payment of governmental benefits (if applicable) to be paid to the provider.

Date: _____ Signature: _____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received a copy of the Patient Notice of Privacy Practices from Little Rock Children's Clinic, P.A. effective December 1, 2015.

Date: _____ Signature: _____



Financial Policy

Our focus is to provide first-class medical care to our patients and families. For us to continue to provide such, we must receive prompt payment. A financial policy has been developed for the following reasons:

1. To help meet the financial obligations of the practice.
2. To follow terms outlined in insurance contracts.
3. To help families understand their financial responsibilities for the services provided by LRCC.

THINGS TO BRING TO EACH APPOINTMENT

- **Current Insurance Card**
- **Valid Photo ID (must be an unexpired Driver's License, State Photo ID, etc.)**
- **Copayment-** MUST be paid at the time of service at check-in. (Payment methods accepted are cash, and debit/credit card). We do not accept checks.

INSURANCE- WHAT YOUR RESPONSIBILITIES ARE

- It is your responsibility to keep our office updated with all your current/correct insurance information. **If the insurance information you provide to our office is incorrect- you will be responsible for payment.**
- It is your responsibility to understand your insurance benefits concerning covered services and participating laboratories. There may be limitations on annual well care, sports physicals, hearing, and vision screenings, etc. You are responsible for the verification of insurance benefits and knowledge of your financial responsibility for services provided by our office for your child. Knowledge of your policy will ensure you are not left responsible for unexpected medical expenses.
- According to your insurance plan, you are responsible for all co-payments, deductibles, coinsurance, and non-covered services.
- If your insurance carrier requests other information from you, such as evidence of coordination of benefits, they will not reimburse our office until you provide the information. If you fail to comply in a timely manner, you will be responsible for those charges.
- It is your responsibility to know if a written referral or authorization is required to see a specialist, whether a pre-authorization is required prior to a procedure (ex: MRI or CT scan), and what/how services are covered.
- Your insurance coverage and benefits are a contract between you and your insurance company. Therefore, all disputes must be handled between you and your insurance company.
- **Newborns-** Insurance carriers require that newborn infants be enrolled within 28 days of birth. If you fail to enroll your infant within 28 days of birth, your child will not have insurance coverage and you will be responsible for payment of any charges.
- **Add on codes-**After hours, Holiday hours and additional billing codes are required at times to be billed to the patient and or insurance. It is strictly up to your insurance carrier on coverage guidelines for these add on codes. Contact your insurance carrier directly for payer specific coverage guidelines. Patients will be responsible for cost share related to certain codes.
- As a courtesy to our parents, we can address well child visits, chronic medical conditions and acute visits on the same day to avoid extra visits. At times insurance carriers will process these claims as patient responsibility. It is up to your insurance carrier to decide coverage guidelines.

CO-PAYS: If insurance requires a co-payment, it must be paid at each visit (time of service). The co-pay **MUST** be paid by the person who brings the child in for the visit, payment must be made via phone OR in our patient portal before the visit.

DEDUCTIBLES: If your insurance plan has a "deductible," this amount is your financial responsibility. We can verify most deductible amounts on the date of service and expect payment for this amount on the date of service. **A minimum of \$150.00 will be collected.**

COLLECTIONS AND OUTSTANDING BALANCES

- If you are unable to pay an outstanding balance in a single payment, we will work with you on a payment plan. Please contact our billing office to review and establish payment options.
- If no payment plan has been established and no payment has been received past 90 days from the date of the first statement, we may submit your account to our collection agency. If your account is sent to our collection agency, a 27 % collection fee will be added.
- Patients with unpaid balance accounts or accounts that have been sent to collections may be discharged from our practice.

REFERENCE LABS

- If your doctor sends specimens to a reference lab, you will receive a statement from the reference lab.

MOTOR VEHICLE ACCIDENT (MVAs)

- LRCC does not bill Third Party Insurance Companies (Auto/Boat/Motorcycle) for visits related to MVAs. Our office will mail a statement the next day of business following your appointment to provide to your insurer covering the MVAs. If the insurer has not paid within 60 days, you will be responsible for paying the balance.

WELL CHILD CHECK-UPS/ IMMUNIZATIONS:

- Some policies may require Wellness copayment, please be sure you are aware of these requirements with your insurance. In addition, some employer-financed plans do not cover AAP Bright Futures recommended screenings, such as vision or hearing tests. If this is the case, you will be responsible for these. In most cases, these screenings are less than \$10.00.
- Immunizations are available in our office, if insurance does not cover immunizations, payment will be required at the time of service. All immunizations provided in our office are also available at your local health department for free.

SECONDARY BILLING OF ARKIDS/MEDICAID

- Please be aware in instances where you have more than one insurance coverage, ARKID/Medicaid will be billed as secondary insurance. You are responsible for knowing your primary policy's coverage of services.

ARKIDS/MEDICAID

- You are responsible for being aware of the expiration date of ARKIDS/Medicaid eligibility (coverage period, usually this is on his/her birthdate.) You must reapply for Medicaid before the expiration date. Go to your local Department of Health and Human Services (DHS) office, (3) three months before the expiration date of eligibility and complete the new application. **WE CAN NOT SCHEDULE A CHECKUP FOR YOUR CHILD UNTIL HIS/HER ELIGIBILITY IS CURRENT AND ONE OF OUR DOCTORS ARE ASSIGNED AS PRIMARY CARE PHYSICIAN (PCP).**

DIVORCES/SEPARATED PARENTS

- LRCC does not get involved in disputes between divorced/separated parents regarding financial responsibility for their child/children's medical expenses.
- Both parents/legal guardian(s) are responsible for payment for services rendered to a minor child.
- If an account is sent to collections, **BOTH** Parents will be turned over for responsibility to pay.

SAME-DAY CANCELLATION/NO SHOWS

- Our Electronic Health Records (EHR) system tracks NO SHOW appointments. Appointments canceled less than 24 hours before your child/children's appointment time will be considered a no-show. After (3) three no-shows, your child and/or family can be dismissed from the clinic (LRCC). Same-day cancellations and/or no-shows will follow a rolling calendar schedule.

Guardian/Parent Signature

Date

If you have any questions, please contact our Billing/Collections department.

Revised 8/19/2024