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BRENTWOOD CHILDREN'S CLINIC

Appointment Cancellation / No-show Policy Agreement

We at Brentwood Children's Clinic are committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from receiving care.

Please call us at (615) 261-1210 by 10:00 a.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00 p.m. on Friday.

If prior notification is not given as noted above, you will be charged $30 for the missed appointment.

Please sign below to confirm receipt of this policy.

_____

Name (Parent/Guardian if under 18)

_____

Signature (Parent/Guardian if under 18)

_____

Date

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Registration Form

Section 1 – *Patient Information.*

Patient (Legal) Last Name	First Name (Legal)	Middle Name	Preferred Name

Date of Birth	Gender	Social Security Number	Primary Care Physician
/ /	Female ☐ Male ☐	- -	

Ethnicity (check one)	Race (check one)
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Specify	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Hawaiian Native or Pacific Islander ☐ White ☐ Decline to Specify

Patient Address (Number, Street, Apt#)	City, State, ZIP
Mailing/Billing Address (Number, Street, Apt#) *If same as above, leave blank*	**City, State, ZIP**
Best Contact Phone Number	

Section 2 – *Parent or Legal Guardian Information.*

Parent/Legal Guardian 1 Full Name (First/Last)	Date of Birth	Social Security Number
	/ /	- -
Primary Phone:	**Alternate Phone:**	
Primary Email:	**Relationship to Minor:**	
Address:		

Parent/Legal Guardian 2 Full Name (First/Last)	Date of Birth	Social Security Number
	/ /	- -
Primary Phone:	**Alternate Phone:**	
Primary Email:	**Relationship to Minor:**	
Address:		

Section 3 – *Emergency Contact Information.*

Emergency Contact's Full Name (First/Last)	Primary Phone	Relationship to Patient

PREFERRED METHOD OF CONTACT FOR *APPOINTMENT REMINDERS*: ☐ Text Message ☐ Phone Call ☐ E-mail

Do you have a copy of your insurance card with you today? ☐Yes ☐No

Insurance Information	Primary Insurance	Secondary Insurance (if applicable)
Insurance Company Name		
Claims Mailing Address		
Provider Phone Number	( ) -	( ) -

Subscriber's Full Name (*Primary* Insurance)	Date of Birth	Social Security Number
	/ /	- -
Subscriber's Full Name (*Secondary* Insurance)	**Date of Birth**	**Social Security Number**
	/ /	- -

INSURANCE BENEFIT ASSIGNEMENT

As a courtesy to our patients, we will file your insurance if you are covered under a plan that we participate with. By signing below, I hereby assign insurance benefits to Brentwood Children's Clinic, PC. I also authorize BCC to release any information necessary for payment of the claim to my insurance carrier at their request. I also understand that I am fully responsible for payment of this account if my insurance information is incorrect, coverage is terminated, or for failure to provide information in a timely manner.

PAYMENT OF ACCOUNT

Payment is expected at the time of service. Deductibles, Co-insurance, and Co-pay's that occur from previous dates of service are expected to be paid in full within a timely manner, as determined by Brentwood Children's Clinic. Your child's health is important to us. If your account will cause financial hardship, please call our office immediately to make payment arrangements. Failure to contact our office in a timely manner may cause interruption in your child's healthcare or well visits. If your account becomes delinquent, we may send your account to an outside collection agency. If your delinquent account goes to court, you will be responsible for all court costs and attorney fees incurred. By signing below, I understand the payment policies of Brentwood Children's Clinic.

CONSENT FOR TREATMENT

My signature is to certify that I, Parent/Legal Guardian of patient, request treatment of my minor child by the physician and/or qualified staff of Brentwood Children's Clinic.

INFECTION CONTROL CONSENT

By signing below, I understand that it may be necessary for my child's blood to be tested if any employee is exposed by needle stick or any other method of exposure to protect the staff of Brentwood Children's Clinic against the possible transmission of blood borne disease. The results are confidential, and the testing is at no cost to the patient or responsible party.

NOTICE OF PRIVACY POLICIES

I have received a copy of the Brentwood Children's Clinic, PC *Notice of Privacy Policies* and have been given an opportunity to review this document. I understand that Brentwood Children's Clinic, PC has the right to change its *Notice of Privacy Policies* from time to time and that I may contact Brentwood Children's Clinic, PC at any time to obtain a current copy of the *Notice of Privacy Policies*.

_____ _____

Parent/Legal Guardian Signature **Date**

_____

Parent/Legal Guardian Printed Name

_____ _____

Witness Signature **Date**

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BRENTWOOD CHILDREN'S CLINIC

Confidential Communication Request (HIPAA Form)

Consent to Leave a Telephone Message for *NORMAL* Lab and Test results

On occasion, Brentwood Children's Clinics (BCC) patients or parents are not available when we call them with test results. BCC would like to be able to leave detailed telephone messages for NORMAL test results (for example, lab, vision, hearing, etc.) when possible. In order to protect your privacy, we need your written permission to leave detailed telephone messages on your answering machine or voice mail system for NORMAL test results only.
Choose one of the following:

☐ I DO CONSENT to BCC to leave detailed telephone messages as follows:
I, _____, give BCC and their designated staff permission to leave telephone messages regarding NORMAL test results. I understand that a message will NOT be left on my voicemail if the results require further discussion.

☐ I AGREE that the telephone number for this communication is:
(please circle one)
_____-_____-_____ home work cell
and the message will only be left on this telephone number.

☐ I DO NOT CONSENT to BCC to leave detailed telephone messages.

Your selection is for the following children and will remain in effect until you rescind it in writing by filling out a new Confidential Communication Request Form.

Patient Name	DOB
_____	_____
_____	_____
_____	_____
_____	_____

Signature _____ Date _____

Relationship to patient(s): _____

(Please continue to back page)

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Confidential Communication Request (HIPAA Form)

The following are a list of contacts who have my permission for the selected items below:

- ☐ Discuss Medical Care
- ☐ Discuss Medications
- ☐ Make/ Change Appointments
- ☐ Bring Child/ Children to appointments
- ☐ Pick-up forms/medical records

Name / Relationship	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name _____

Parent Signature _____ Date _____

BRENTWOOD CHILDREN'S CLINIC

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to contact a member of our billing staff at 615-261-1214.

1. On arrival, please present your current insurance card at every visit. Review and sign the visit sheet. This is your verification of correct insurance and your consent to bill them on your behalf. **If the insurance company you designate is incorrect, you will be responsible for the payment of the visit.**
2. According to your insurance plan, you are responsible for all co-pays, deductibles, and coinsurance. Not all plans cover annual well appointments, sport physicals, hearing and vision screenings and other tests. Before scheduling annual appointments, verify your benefits and coverage with your insurance company. **If services rendered are not covered the charges are your responsibility.** In addition, copays, deductibles, co-insurance, and any self-pay balances must be paid at the times of service. Unfortunately, we cannot split bill the balance due between parents, guardians and or responsible party. Payment is due in full at the time of service. We can provide you with receipts detail billing for you to work out payments with others.
3. If our physicians do not participate in your insurance plan, payment in full is due at time of service. If you have no insurance, payment is due at time of service.

Our billing process is as follows:

1. The patient is seen and physician completes chart and signs off on services rendered.
2. Claim is sent to the insurance company and benefits are assigned. (Deductible, co-pays, co-insurance.) We receive insurance payment and notification of any patient responsibility.
3. Approximately 15-30 days after visit Statement is mailed to the guarantor.
4. If no payment is received 30-60 days after visit, statement 2 and phone call are made to responsible party.
5. If no payment is received 60-90 days after visit, statement 3 and phone call 2 made to responsible party.
6. After >90 days after visit, a delinquent account letter sent to responsible party. Then 10 days after letter is sent, the account is turned to delinquent and reviewed for collections and/or dismissal. Appointments cannot be made unless speaking with the billing department.

I have read and understand the financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above

_____ _____

Signature of Responsible Member Date