# PEDIATRIC PATIENT REGISTRATION

Matthews-Vu
Healthcare for Children and Adults

Patient: _____ Date: _____
(Last Name, First Name, Middle Initial)

SSN: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

Preferred phone number:_____ Preferred email: _____

**Parent/Guardian #1:**_____ Relationship : _____ Date of Birth: _____
(Last Name, First Name, Middle Initial)

Address (if different from patient): _____

Preferred Phone Number: _____ Employer: _____

**Parent/Guardian #2:** _____ Relationship: _____ Date of Birth: _____
(Last Name, First Name, Middle Initial)

Address (if different from patient): _____

Preferred Phone Number: _____ Employer: _____

* If parents are not living together or if the child does not live with the parents, what is the child's custody status?

_____

**PLEASE LIST ALL PERSONS LIVING IN THE CHILD'S HOME:**

| Name | Relationship to Child | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are there siblings not listed? If so, please list their names and ages and where they live. _____

_____

**IN CASE OF EMERGENCY, PLEASE CONTACT:**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**PERSONS AUTHORIZED TO ACCOMPANY AND PROVIDE CONSENT FOR TREATMENT OTHER THAN PARENTS:**

Name: _____ DOB: _____ Relationship: _____ Phone: _____

Name: _____ DOB: _____ Relationship: _____ Phone: _____

**PREFERRED PHARMACY NAME/LOCATION:**_____

**NAME OF INSURED/RESPONSIBLE PARTY:** _____ Relationship to Patient: _____

Social Security Number: _____

**If different from parent/guardian please provide**:

Date of Birth: _____ Preferred Phone Number: _____ Other: _____

Address: _____

Employer: _____

Name of Primary Insurer: _____

Policy#: _____ Group #: _____

Name of Secondary Insurer: _____

Policy #: _____ Group #: _____

**I understand that payment of all medical care is due at the time of service.** The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Matthews-Vu Medical Group to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Matthews-Vu Medical Group.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent/Guardian Date

_____

Printed name

How did you learn about our practice? _____

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**HIPAA ACKNOWLEDGEMENT NOTICE - Pediatrics**

**PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES**

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Matthews-Vu Medical Group and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Matthews-Vu Medical Group are not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Matthews-Vu Medical Group reserves the right to amend the Notice of Privacy Practices from time to time and that I may, at any point, request a copy of the current Notice.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of poor consent and authorization. I understand the consent musts be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer named.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Printed Name Child's Date of Birth

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# Notice of Privacy Practices – Consent to Share

We at Matthews-Vu Medical Group, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

To assist us in protecting your privacy, please complete the following: (***please print***)
Patient Name _____Date of Birth: _____

Preferred Contact number(s): May we leave a detailed message? Y N (***circle one***)

Home: _____ Cell: _____ Work: _____
Yes No Yes No Yes No

**Please list the people that we have your permission to discuss your medical records and are allowed to have a copy of your information:**

| Name of person (s)/Relationship | Date of Birth | Phone Number (if available) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

This authorization applies to the following information: (***please initial***):
All Records _____ Labs _____ Imaging Records _____ Immunizations_____

Mental Health/Behavioral Health _____ Substance Abuse _____

***I have been made aware and have had the opportunity to review the privacy policies of Matthews-Vu Medical Group.***

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

Patient Name**:** _____ **Date of Birth:** _____

# Financial Payment & Attendance Policy

Thank you for choosing Matthews-Vu Medical Group as your primary care provider. As part of our commitment to offer quality medical and affordable health care, we are also committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. If you have any questions about our fees, or your responsibilities, please ask. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

1. **Insurance** – Our office participates in most insurance plans. If you are not insured by a plan we have a contract with, you will be responsible for payment for all services. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, you will be responsible for payment for all services until we can verify your coverage. Knowing your insurance benefits is your responsibility. Your insurance benefits is a contract between you and your insurance company; we are not party to that contract. Failure to provide complete insurance information can result in patient responsibility for the entire bill. Please contact your insurance company with any questions you may have regarding your coverage. As a courtesy, we will file all applicable office charges with your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If the provider deems **medical necessity** for certain services/test and these services/tests are not covered or not considered reasonable or necessary by insurers, the patient is financially responsible.

2. **Co-payments and deductibles** – **All co-payments, deductibles and/or co-insurance must be paid at the time of service**. We accept Cash, Checks, Master Card, Visa, American Express or Discover. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payments at each visit. Patients with **high deductible health insurance plans** will be required to pay a deposit of $70 for each visit (unless you have a letter from your insurance company stating you have reached your deductible). Patients are responsible for working with their insurance company to know if they have reached their deductible. If a patient pays $70 and the insurance company determines the patient has already met this year's deductible, the business office will issue a refund. If you are not able to pay at the time of service you must call the business office and set up a payment plan prior to your appointment.

3. **Self-pay Accounts** – Patients without insurance coverage, or patients without an insurance card on file with our practice. It is the patients' responsibility to know if Matthews-Vu Medical Group participates with their health insurance plan. Self-pay patients will be required to make a deposit of $70 prior to appointment. After the visit, the patient will be required to pay the estimated remaining balance. After the claim has been reviewed by the business office coding team, a final bill will be determined and reconciled against the payment paid at time of service. If a balance is due from patient, the business office will submit a statement to the self-pay patient. If a credit balance is owed to the patient, the business office will issue a refund.

4. **Return Checks** – The charge for a returned check is $30 payable in cash or credit card. This will be applied to your account in addition to any bank-insufficient-funds charge incurred by the practice. You may be placed on a cash or credit card only basis following any returned check.

5. **Outstanding Balance Policy** – Patients will receive a monthly statement with any outstanding balance of $5.00 or more. Please be aware that the balance after insurance pays is the patient's responsibility. If your insurance company does not pay your claim in 60 days, the balance may be billed to you. Patients can make payments by paying with check or by going online and using the patient portal to process a credit card payment. Patients can also call the billing office at (719)884-2799 to process a credit card payment over the phone. We accept Checks, Master Card, Visa, American Express or Discover. If your account becomes past due over 60 days, you will receive a phone call. On a case by case basis, a payment plan can be established with a credit card on file.

6. **Nonpayment** - If there was no attempt on the patient's behalf to contact and set up a payment plan, and your account is over 60 days past due, you will receive a letter stating you have 30 days to pay your account in full. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency (patient responsible for collection fees) and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

7. **Late Appointments** – Matthews-Vu Medical Group asks all patients to arrive at least 20 minutes early for their scheduled appointment. If you arrive 15 minutes after your appointment time, you may be offered another appointment with the same provider or with another provider.

8. **Missed Appointments** – Matthews-Vu Medical Group requires 24-hour notice for appointment cancellations. Appointments missed that are not previously cancelled may be charged a fee of $50.00. If we determine a patient is a habitual offender of missed appointments (3 within 12 months), we may request a $50.00 deposit prior to scheduling the next appointment. Patients may also be subject to discharge from the practice following continuity of care guidelines. Please help us to serve you better by keeping your scheduled appointment.

This financial payment and attendance policy helps the office provide timely quality care to our valued patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment and attendance policy. Please let us know if you have any questions or concerns.

## ASSIGNMENT AND RELEASE / MEDICARE AUTHORIZATION

I request that payment of authorized medical benefits to include all Medicare benefits be made on my behalf to Matthews-Vu Medical Group for any services furnished me. I authorize any holder of medical information about me to release to the insurance payor and/or the Center of Medicare and Medicaid Services or its agents any information needed to determine benefits payable for billed services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes the release of information to the insurer or agency shown in Medicare assigned cases, Matthews-Vu Medical Group agrees to accept the determination of the Medicare carrier. The patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

_____ _____

Patient/Guardian Signature Date

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# Surprise/Balance Billing Disclosure Form

**Surprise Billing – Know Your Rights**

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

**What is surprise/balance billing, and when does it happen?**

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

**When you CANNOT be balance-billed:**

**Emergency Services**

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

**Nonemergency Services at an In-Network or Out-of-Network Health Care Provider**

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

**You have the right** to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

**Additional Protections**

- Your insurer will pay out-of-network providers and facilities directly.

- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

***If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.***

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department at 719-884-2799, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Patient Name: _____ DOB: _____
(Please print)

Signature: _____ Date: _____

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# *(Incoming Records)*
# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

**Patient:** _____

**Date of Birth:** _____

**Telephone Number:** _____

| **Requesting Records from:** | **Where to send the records to:** |
|---|---|
| Name/Facility: _____ | Matthews-Vu Medical Group |
| Attention: _____ | Attention: Medical Records |
| Address: _____ | 4190 E Woodmen Rd, Ste 100<br>Colorado Springs, CO 80920 |
| City: _____ State: _____ Zip: _____ | |
| Phone: (____)_____ FAX: (____)_____ | Phone: (719)632-4455 Fax: (719)633-4613 |

**Please send records from the following date range:** from: _____ to: _____

- ☐ All
- ☐ History and Physical
- ☐ Consultation Notes
- ☐ Progress Notes
- ☐ Labs
- ☐ Other:_____
- ☐ Behavioral Health

**Purpose of requested use or disclosure:**

- ☐ Continuing Care
- ☐ Patient Request*
- ☐ Insurance*
- ☐ Legal*
- ☐ Other

***Copy Fee**: We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Base fee of $20.00 per chart for personal records. Please make checks payable to Bactes.*

**I specifically authorize release of the following information (check and initial as appropriate):**

- ☐ Mental health treatment information — Initial if requesting: _____
- ☐ HIV test results — Initial if requesting: _____
- ☐ Alcohol/drug treatment information — Initial if requesting: _____

***If not checked and initialed, the records containing such information can NOT be released.***

Duration: This Authorization expires [insert date]: _____
***If no date is given; this authorization will expire 6 months from the signature date.***

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Matthews-Vu. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient and no longer protected by federal privacy regulations.

Conditioning: I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

**Patient Signature:** _____ **Date:** _____

**Legal Representative Signature:** _____ **Relationship to Patient:** _____