# PEDIATRIC PATIENT REGISTRATION

Matthews-Vu
Healthcare for Children and Adults

Date: _____

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

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

Address: _____

Preferred phone number: _____ Preferred email: _____

**Parent/Guardian Information**

**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?

_____

**Name of Responsible Party:** _____

Relationship to Patient: _____ SSN: _____

**Medical Insurance** **Check Box if you are Self-Pay** ☐

**Primary Insurance Company:** _____

Policy #: _____ Group #: _____ Plan #: _____

Policy Holders Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

**Secondary Insurance Company:** _____

Policy #: _____ Group #: _____ Plan #: _____

Policy Holders Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

**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: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**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.

_____

_____

**PREFERRED PHARMACY NAME/LOCATION:**_____

**I understand that payment of all medical care is due at the time of service.** The patient, 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

## 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 prior consent and authorization. I understand the consent must 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

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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 (HIPAA).

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

Parent/Guardian #1_____ Parent/Guardian #2:_____
(Last Name, First Name, Middle Initial) (Last Name, First Name, Middle Initial)

**Please list any *additional* people that have your permission to discuss your/ your child's medical records and are allowed to have a copy of your/ your child's 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. 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, etc.).

1. **Insurance** – Our practice participates in most insurance plans, but if you have an insurance plan that we do not accept, you will be responsible for payment for all services. Your insurance benefits are a contract between you and your insurance company; it is your responsibility to understand your insurance coverage. We must have your complete and up to date insurance information at each appointment. If we do not have this information, we cannot file all applicable office charges with your insurance company, and you will be responsible for payment for services rendered. 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 your insurance, you will be financially responsible. **For newborns**, we will provide care for **60 days** of life under an insurance pending status while the child's application for insurance is being processed. If the child's application is denied or not processed within 60 days, the outstanding visits will be changed to self-pay and all self-pay policies will be applied to any outstanding claims for the child.

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. 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. We must collect co-payments and deductibles at the time of service as this is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you have a **high deductible health insurance plan** you will be required to pay a **deposit of $70** at each visit (unless you have a letter from your insurance company stating, you have reached your deductible). You are responsible for working with your insurance company to know if you have reached your deductible. If you pay $70 and the insurance company determines that you have already met your deductible, the business office will issue a refund.

3. **Self-pay Accounts** – You will be considered self-pay if you do not have insurance coverage, or we do not have your correct insurance information on file. Self-pay patients scheduled for **non-urgent** visits will be required to make a **deposit of $70 prior to each visit.** After the visit a claim will be generated for any additional charges and a final bill will be determined and reconciled against the payment paid at time of service. If a balance is due, you will be responsible for paying the remaining balance. If a refund is owed to the patient, the business office will issue a refund. For **Urgent Care** visits, a flat fee of **$150** will be due up-front before being seen and any additional costs will be paid immediately after the visit.

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** – You will receive a monthly statement with any outstanding balance of $5.00 or more. Please be aware that the balance after insurance pays is your responsibility. If your insurance company does not pay your claim in 60 days, the balance may be billed to you. You can make payments by paying with a check or by going online and using the patient portal to process a credit card payment. You can also call the billing office at (719)884-2799 to process a credit card payment over the phone. 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 your 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 check in **15 minutes or more after your appointment time**, your appointment is not guaranteed. We will determine if we have openings with the same provider or with another provider on a case-by-case basis.

8. **Missed Appointments** – Matthews-Vu Medical Group requires a minimum 24-hour notice for rescheduling appointments or cancellations. **Missed appointments not cancelled or rescheduled at least 24 hours prior to the appointment will be charged $50.00**. (This does not apply to Medicaid patients per Medicaid rules) If you miss 3 appointments within a 12-month period, we may request a $50 deposit prior to scheduling another appointment and you may be subject to discharge from the practice following continuity of care guidelines.

9. 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. 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 provided to 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: _____