DOCTORS OF CHILDREN

PATIENT **Introduction Sheet**

Today's Date: _____

***CHILD'S LEGAL NAME*:** _____ **M/F:** ____ **DOB:**_____

Ethnicity: __ Not Hispanic / __ Hispanic / __ Prefer Not to Answer

Race: __ White / __ Black-African Am / __ Am. Indian / __ Native HI-Pacific IS / __ Asian / __ Prefers not to answer

Custodial Parent's Information:

Custodial's Parent(s): _____

Address: _____ ZIP CODE: _____

Preferred Phone: _____ Phone #2: _____ Phone #3: _____

Bill Payer's Information:

Bill Payer's Name: _____

Address: _____ ZIP CODE: _____

Preferred Phone: _____ Phone #2: _____ Phone #3: _____

Emergency Contact: _____ Phone #: _____

Primary Insurance Company: _____ Employer: _____

I.D. #: _____ Group#: _____ Insured's Name: _____ DOB: _____

Secondary Insurance Company:_____ Employer: _____

I.D. #: _____ Group#: _____ Insured's Name: _____ DOB: _____

Medicaid: _____YES _____ NO

Authorization and Release

I authorize Stacey L. Houston, Kelly J. Murry, Anne Bigbee, Colleen Hanna-Slagle, Pramod Shrestha, and Kali Welling to assess and treat the above named patient. I also authorize the health care provider to release any information including the diagnosis and treatment or examination rendered to my child during the period of such care to third party payors and/or health practitioners. I authorize and request that my insurance company to pay directly to the doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may not cover all services provided or ordered. I agree to be responsible for payment (in accordance with Doctors of Children's Financial Policy (see back)) of all services rendered on my behalf of my dependents.

Signature (insured or authorized person): _____ Date: _____

I authorize the following (step-parent, grandparent, daycare, school (someone other than the biological parents or legal guardians)) to seek medical care, obtain medical information, and/or discuss medical treatment of the above named child for a period of one year:

_____, Relationship: _____ Phone: _____

_____, Relationship: _____ Phone: _____

Signature and Relationship to Child: _____ Date: _____

DOCTORS OF CHILDREN, LINCOLN P.C.
Financial Policy

It is the intention of all personnel at Doctors of Children to provide for your child's health needs as thoroughly and as efficiently as possible. We therefore ask for your assistance in helping us to keep the cost of billing to a minimum.

Insurance – Please bring your insurance card to your appointment!
We participate with most major insurance companies in this region including Medicaid and managed care plans. DOC will file your claim for you. You will be billed for any balance due (including deductible, coinsurance) once insurance has processed your claim. This balance is due within 15 days. Regardless of your medical insurance coverage, our practice relies on you for settling your account.

Co-Payments are an agreement between you and your insurance company and will be collected by the receptionist at check-in. Our contract with your insurance company requires us to collect the co-pay from you. **Doctors of Children considers the "responsible party," the person bringing the child to the appointment.*

Non-covered services - Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Some insurances have a "timely filing" restriction. If we do not have the correct information, any denied claims will be the client's responsibility. Payment is due upon receipt of a statement from our office. If you are unable to pay the balance in full, please call 402-423-2739 to arrange payments (See Payment Plan below.)

Health Screenings-During well visits we perform recommended screenings appropriate to age and seek to uncover any conditions that may lead to suboptimal health in years to come. In our experience, some insurance plans cover these screenings, and some do not. Because there are so many different insurance companies, we do not know in advance what will and will not be covered. It is the patient's responsibility to decline screenings or pay for these if the insurance does not cover them.

Uninsured Patients – If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

Past Due Accounts/Delinquent Accounts - Visits that have not been paid within 30 days of initial billing will be considered **past due**. Visits that have not been paid within 60 days of initial billing will be considered **delinquent**. Visits that have not been paid within 90 days of initial billing will be considered for collection by Professional Choice Recovery Inc. and/or possible termination of the patient/physician relationship. Termination of the patient/physician relationship will be made in writing with a 30-day notice of emergency-only treatment (cash at time of service.) No appointments will be scheduled after official termination has been made.

Payment Plan – If an account is unable to be paid in full; periodic payment arrangements can be made. These arrangements are made with the office manager.

Methods of Payment - We accept cash, check and Mastercard or Visa. Payments can also be made through our portal.

Returned Checks – If a check is returned for insufficient funds, our bank uses PayTek to handle the returned check (a service fee is charged).

Methods of Contact- I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.
February 2021

I have read & understand Doctors of Childrens HIPAA Policy and agree to it's content. Copies available upon request.

Signature (insured or authorized person): _____ **Date:** _____