New Patient Information

COTTONWOOD PEDIATRICS
WWW.COTTONWOODPEDS.COM
700 MEDICAL CENTER DR, STE 150
NEWTON, KS | 67114
P:316-283-7100 | F:316-283-7118

CHILD'S FIRST NAME MIDDLE LAST

DATE OF BIRTH ☐ FEMALE ☐ MALE STREET ADDRESS

MAILING ADDRESS (IF DIFFERENT) ZIP CODE CITY STATE

SOCIAL SECURITY # MAIN PHONE # OTHER PHONE #

RACE ETHNICITY LANGUAGE

I DECLINE TO STATE MY CHILD'S RACE/ETHNICITY/LANGUAGE (PLEASE INITIAL)

PARENT INFORMATION

FULL NAME DATE OF BIRTH

☐ MOTHER ☐ FATHER SOCIAL SECURITY # SAME ADDRESS AS CHILD? ☐ YES ☐ NO

MAILING ADDRESS (IF DIFFERENT) CITY STATE

ZIP CODE EMAIL PLACE OF EMPLOYMENT

SAME PHONE # AS CHILD? ☐ YES ☐ NO PHONE # (IF DIFFERENT)

FULL NAME DATE OF BIRTH

☐ MOTHER ☐ FATHER SOCIAL SECURITY # SAME ADDRESS AS CHILD? ☐ YES ☐ NO

MAILING ADDRESS (IF DIFFERENT) CITY STATE

ZIP CODE EMAIL PLACE OF EMPLOYMENT

SAME PHONE # AS CHILD? ☐ YES ☐ NO PHONE # (IF DIFFERENT)

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME

POLICY/ID #

GROUP #

POLICY HOLDER'S NAME AS LISTED ON CARD

IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THEIR INFO:

FULL NAME

DATE OF BIRTH ☐ FEMALE ☐ MALE

SOCIAL SECURITY #

MAILING ADDRESS

EMPLOYER

PHONE #1 PHONE #2

SECONDARY INSURANCE INFORMATION

(IF APPLICABLE)

INSURANCE COMPANY NAME

POLICY/ID #

GROUP #

POLICY HOLDER'S NAME AS LISTED ON CARD

IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THEIR INFO:

FULL NAME

DATE OF BIRTH ☐ FEMALE ☐ MALE

SOCIAL SECURITY #

MAILING ADDRESS

EMPLOYER

PHONE #1 PHONE #2

You must list ALL health insurance policies and ask for additional pages if necessary. Please present insurance card(s) at ALL visits.
It is YOUR responsibility to know your insurance exclusions, limitations, benefits and eligibility.

PATIENT PRIVACY NOTICE

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In accordance with Federal Privacy Law (Health Insurance Portability and Accountability Act, HIPAA), Cottonwood Pediatrics keeps medical information and records confidential, and will only use them for patient treatment, health care operations, billing purposes and research.

TREATMENT:	Our pediatricians, clinicians, nurses and staff will use your child's medical information to give him/her the best possible care.
HEALTH INFORMATION EXCHANGE	We are part of the Kansas Health Information Network (KHIN) and will release patient immunizations to the Kansas Immunization Registry. Future releases may include demographics and clinical data such as allergies, chronic conditions and general health information to KHIN.
HEALTH CARE OPERATION:	Cottonwood Pediatrics will use this information for appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.
BILLING PURPOSES:	Cottonwood Pediatrics will use your child's medical information to bill the appropriate third party(ies) for your child's care. You may choose to not have us bill your insurance carrier, but only if you are paying costs in full on the date of service. The Cash Pay Request Agreement must be completed. If you choose this option, your child's medical information will not be disclosed to your insurance carrier or health plan.
RESEARCH:	Cottonwood Pediatrics may use your child's medical information for research purposes in coordination with Heartland Research. As a business associate of Cottonwood Pediatrics, Heartland Research has signed a contract which states that they will appropriately safeguard your personal information.

We are legally required to tell you that your child's personal health information cannot be sold by anyone without your express written authorization, and only after disclosure by the seller of the purpose of sale. However, **Cottonwood Pediatrics does not sell any of this information**, and never has.

DISCLOSURE OF INFORMATION WITH EXTENUATING CIRCUMSTANCES

1. Health information will be given to family members in case of an emergency or under other circumstances with proper authorization and documentation.
2. Health information may be given to other physicians or institutions under emergency situations.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is served on this office, or by Court order.

If you have any questions or concerns about this privacy policy, you may ask to speak to the Cottonwood Pediatrics Privacy Officer, at 316-283-3627. In the event of a breach of security, those parents whose children's private health information may have been compromised will be notified.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the medical/financial information we already have. Parents will be notified if any significant changes are made. You may ask for a copy of this privacy notice from any clerical employee at any time.

I hereby acknowledge I was offered a copy of this Notice and either declined or received a copy of such Notice.

Child(ren)'s name(s):

Parent/guardian's signature

Today's date

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

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Thank you for choosing Cottonwood Pediatrics as your child's healthcare provider. We are committed to providing the best medical care possible for your child. Please review the following policies.

Consent to Treat: By signing, you consent to treatment in our office or in the hospital. This includes any examinations, tests, immunizations, or other procedures which may be deemed advisable or necessary. You will be notified of any such testing and you have the right to an explanation of any procedures and their risks, benefits, alternatives, and charges before they occur. Your signature here consents to these procedures. It is your responsibility to inquire about and/or decline any such procedures. The occurrence of a procedure indicates that you understand the risks and benefits and have received a satisfactory response to your questions, if any.

Insurance: If the patient is covered by an insurance plan with which we contract, we will adhere to the terms of that contract and will file your insurance claim for you. By signing below, you

- allow us to file this claim for you and assign all insurance benefits arising from the claim to be paid directly to our office.
- accept responsibility for any charges not covered by your insurance plan and which are legally billable to the insured; you accept full responsibility if your insurance is terminated or otherwise invalid.
- grant us permission to file an appeal on your behalf (in accordance with applicable law) if the insurance company denies or restricts payment.

If the patient is covered by a plan with which we do not participate, we may provide you with the necessary documentation to file your own claim for reimbursement, and you are expected to pay for care your child received.
If your plan requires any authorization (prior or otherwise) for any service, whether at our office or elsewhere, we will assist you as possible, but the final responsibility for such authorization lies with you.

Financial Policy: Payment of your bill is required by contracts with insurance companies and government entities.
Payments: All applicable co-pays, personal balances, both current and prior, are due at time of service. Charges for our services in the hospital, in-patient, out-patient, or Emergency Room are due and payable upon receipt. We accept cash, check or credit cards. You agree to give us ALL active health insurance cards or policies for your child.

Usual and Customary Rates: We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining. You will be financially responsible for ANY non-covered services, Medicaid or otherwise, performed on your child's behalf by any staff at this office.

Past Due Accounts: Overdue accounts will be referred to a collection agency. Legal and/or collection fees that we pay to secure past due balances will be added to your account.

Account Balances:

- Payment of co-pays is expected and must be paid at time of service.
- If a payment agreement is used, ALL account balances must be paid within 90 days from the date of first statement. Once an amount is over 90 days in arrears, that amount will be required before patients can be seen. No further notices beyond statements within 90 days will be sent.

Balances over $500 for inpatient services from our providers at another facility (such as Newton Medical Center) must be paid in full within 6 months from the date of the first statement. If over 90 days in arrears, that amount will be required before patients can be seen. No further notices beyond statements within 90 days will be sent.

Bad Checks: Checks returned as unpaid by your bank carry a $30.00 fee in addition to the amount of the check.

Policy on Missed Appointments: If you miss 3 appointments in a year without canceling, your account is blocked and you go to walk-in status until you have walked in 3 times. LATE MORE THAN 10 MIN is a MISSED APPOINTMENT. If we have appointments, we may arrange to see you later. If you need further information on this policy, please call.

You may be restricted from scheduling back-to-back appointments if you do not keep them.

We reserve the right to dismiss any patient from our practice, if the patient (or patient's parent/guardian):
- Refuses to actively and appropriately participate in their child's medical care
- Abuses our staff
- Disrupts our office functions
- Refuses to pay copays, co-insurance, provide insurance information, or provide information to their insurance.

These are examples of behaviors that warrant dismissal from our practice. Each situation is evaluated individually.
Please contact our Billing Office if you have any questions or concerns at (316) 283-7100.

I have read the above statements and accept full responsibility for the listed items.

☐ Mother ☐ Father ☐ Guardian

Mother/Father/Guardian's signature Date

Authorization for Release of Patient Health Information and Records

700 MEDICAL CENTER DR, STE 150, NEWTON, KS 67114 | P:316-283-7100 | F:316-283-7118 | COTTONWOODPEDS.COM

Cottonwood Pediatrics

PARENT FULL NAME

PARENT/LEGAL GUARDIAN'S FULL NAME

CHILD 1 FULL NAME — DOB

CHILD 2 FULL NAME — DOB

CHILD 3 FULL NAME — DOB

CHILD 4 FULL NAME — DOB

I AUTHORIZE COTTONWOOD PEDIATRICS TO

☐ disclose information to ☑ request information from ☐ exchange information with (obtain and/or disclose)

HEALTH/MENTAL HEALTH PROVIDER | TELEPHONE | FAX

ADDRESS | CITY, STATE AND ZIP CODE

PURPOSE OR NEED FOR THIS INFORMATION

TRANSFERING ☐ age 18 & over ☐ moving ☐ leaving practice

NOT TRANSFERING ☐ continuing care ☐ specialist use ☐ copies for own use ($20 per child – disk)

THIS AUTHORIZATION IS EFFECTIVE FOR (CHOOSE ONE) 1 YEAR _____

TYPE OF RECORDS

☑ All visit notes - please include growth charts and immunization records

☐ Health care information related to the following treatment or condition:

☐ Other (specify)

I understand that:

- I have the right to revoke this authorization at any time;
- in order to revoke this authorization, I must do so in writing and present **my written revocation to Cottonwood Pediatrics Medical Records Release of Information office** at the above address;
- the revocation will not apply to information that has already been released in response to this authorization;
- the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire one year from the date signed below.

A fee may be charged for preparing, copying and sending records.

I also understand that:

- treatment is not conditioned upon the execution of this authorization;
- if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy;
- regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

Signature | Date

☐ Mother ☐ Father ☐ Guardian