FOSTER CHILD PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date_______________ Male_____ Female_____ Birthdate_______________

Foster Child's Full Name ____
Last First Middle

Medical Card # ____

Foster Parent Name ____

Foster Parent's Home Address ____
Street City State/Zip

Foster Home Phone # (___)______________________

Foster Dad's Work Phone # (___)_________________ Are calls allowed? ___Yes ___No

Foster Mom's Work Phone # (___)_________________Are calls allowed? ___Yes ___No

Anticipated term of foster care: From ____________________ To ______________________

Other patients (children) residing at this address:____________________________________

In case of emergency, call: ______________________________ at (phone#) ______________

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Medical expenses for the foster child above are covered under the Child and Family Services (CFS) contract, thereby assigning financial responsibility to SRS. Any non-covered expenses incurred due to coverage limitations will be submitted to SRS for reimbursement. It is therefore agreed that I am not financially responsible for the expense incurred on behalf of this individual. The information provided is true and accurate to the best of my knowledge.

Signature____ Date__________________

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THE GREAT BEND CHILDREN'S CLINIC P.A.

Great Bend Children's Clinic
1021 Eisenhower Ave, Great Bend, KS 67530
Permission to Seek Medical Care

Child's Name ______________________________ DOB______________

I hereby allow the following individual(s) to seek medical attention for my child:

this permission may include immunizations: YES or NO
this permission my include medications: YES or NO
this permission my include other invasive treatments: YES or NO

- Parents ________________ (Mother) ____________________ (Father)
- Grandparent(s)______________________________________
- Step Parent____
- Other ________________ (Name) ____________________ (Relationship to Patient)

*** ____ ***

Permission to Disclose Private Health Information

I hereby allow *The Great Bend Children's Clinic* to share the following medical health information with the individuals named above:

_______Appointment dates/times
_______Physical Exam details
_______Test Results
______Rx prescriptions/instructions/information
______Immunization Records
______Other Health Information

*** ____ ***

Methods of Disclosure of Protected Health Information(PHI)

Private Health Information (PHI) may be disclosed to the individuals named above in the following forms of communication:

_______Home Telephone
_______Work Telephone
_______Cell Phone
_______Presence during Exam
_______Home Message Machine
_______Work Message Machine
_______Cell Phone Message
_______Written Communication

______________________________ (Parent or Guardian Signature)

______________________ (Date)

This information may be changed or revoked at any time by the patient, parent or guardian.

Great Bend Children's Clinic Financial Policy

Thank you for choosing the Great Bend Children's Clinic as your healthcare provider. We are committed to your health treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy we require you read and sign prior to any treatment.

Self-Pay: If you do not have insurance, our policy is to require full payment at the time of service. We accept cash, checks, Visa or MasterCard credit card payments.

Regarding Insurance: We accept assignment of insurance benefits on your first visit. You are responsible for your co-payment at the time of service. The remaining amount will be billed to you after the insurance has paid. If the charges apply to an unmet deductible, we expect a 20% payment at the time of service. We participate in several PPO organizations in which we have agreed to accept their reimbursement amounts and grant appropriate write offs. Your insurance policy is a contract between you and your insurance company and we ask you to be familiar with it regarding coverage and benefits. We are not a party of the contact. We file insurance as a courtesy to you.

Usual and Customary: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Financial Arrangement: For insurance balance due. Federal Law requires you to sign a financial arrangement in the even that we bill you. If your account lapses over 90 days without payment, we will be forced to start collection proceedings. In this event, you will be responsible for an additional 15% of the collectible balance fee. Should collections of your account require legal action, and additional 15% is added for attorney fees. Please keep our insurance department apprised of your situation so we can work with you before this happens.

Minor Patients: The adult accompanying a minor and the parents (or the guardians of the minor) are responsible for full payment. We do not get involved in billing and collecting from ex-spouses.

Missed appointments: If you are unable to keep your appointments, please inform us as soon as possible. Three "no show" appointments in a one year period may subject you to dismissal from the clinic.

Returned checks: Checks returned to us by your banking institution for insufficient funds will be charged an additional $30.00 service fee.

Non-payment and Overdue accounts: We realize some families experience financial difficulties and our main concern is providing excellent uninterrupted care to your children. We believe that communication of these difficulties is of the utmost importance so we can focus on your children. Please notify our office manager if you need help with financial arrangements. If you ignore or fail to respond to your financial obligations, we will have no choice but to enforce our non-payment policy.

Our goal is to care for your children and our billing team is here to help you with any questions you may have concerning your balance. 620-792-5437. We would like to thank you for choosing Great Bend Children's Clinic. We are committed to provide the best possible care to your child (ren).

By my signature below, Is state that I have read and understand the Financial Policy for GBCC.

____________________ ____________________ ____________________

Parent/Guardian Signature Date Patient Name

____

Printed Name

Great Bend Children's Clinic Policies and Procedures

1. **Insurance Cards**

   Please bring your current insurance card each visit. It is your responsibility to know the benefits and provisions of your individual policy. If you do not provide us with the current insurance information at the time of service, we will be unable to file the insurance claim for you, making you responsible for the cost of all services.

2. **Co- Payments**

   If your insurance policy requires a co-payment, this must be paid before your child is seen. For your convenience we accept cash, checks, Visa and MasterCard.

3. **Forms**

   If you require a form for daycare, pre-school, camp, sports physicals or any other activity we request you bring the form with you to your child's well exam. Please allow up to three business days for the form to be completed.

4. **Missed/Late appointments**

   If you are unable to keep your child's scheduled appointment, we simply as that you call us 24 hours in advance to cancel. If you are more than 15 minutes late for your appointment we may need to ask you to reschedule out of courtesy to our other patients. We will be happy to try and work you in, but you will have to wait until there is an available appointment time ore we may offer you and appointment with another provider, if available.

5. **Prescription Refills**

   If your child is on a controlled medication and you need a refill, we request you notify our office 24 hour in advance to get the prescription written and picked up or 5 business days if you need the prescription mailed. For all other medication refills, please have your pharmacy send us a refill request. These will be completed within two business days.

6. **Returned Mail/ Check**

   Please remember to update our office with any changes in your patient information each time you are in the office. When a check is returned to us no paid by your bank due to insufficient funds or other reasons, the bank charges our account a fee and that cost will be added to your account balance. After 2 returned checks we will no longer accept a check on your account. Your balance will need to be paid by cash, Visa, or MasterCard.

7. **Medical Records**

   If you would like a copy of your child's medical record there is a standard charge as allowed by Kansas Law. At your written request, we will transfer immunizations, growth chart, and last well exam to another physician office on time without charge. A request for additional records will be subject to charge. Records will be transferred within 30 days of written request.

8. **HIPPA**

   We do not fax any medical information to your home or work office. We will fax immunization records to your child's school or daycare.

By my signature below, I state that I have read and understand the above policies for GBCC

______________________	______________	______________________
Parent/Guardian Signature	**Date**	**Patient**

Revised on 12/31/2018

HIPAA Notice of Privacy and Security Practices

Great Bend Children's Clinic
1021 Eisenhower Ave
Great Bend, KS 67530
620-792-5437

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INOFRMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information about you. Including demographic information, that may identify you and that relates to you past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, and our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management if your health care is with a third party. For example, we would disclose your protected health information, to a home health agency that provides care to you. For example, your protected health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For Example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students who are being trained at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign in your name and indicate a physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

Child's Name____

<u>You have the right to inspect and copy your protected health information.</u> Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of. Or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject to lave that prohibits access to protected health information.

<u>You have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your requests. We may require that you pay such fee prior to receiving the requested copies. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notifications purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree with your request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You must complete a form providing information we need to process your request.

<u>You have the right to request to receive confidential communications form us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,</u> upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

<u>You may have the right to have your physician amend your protected health information.</u> If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u> This is a list of disclosures we may make of health information about you, with certain exceptions specifically defined by law. To request this accounting of disclosures you must complete a specific form providing information we need to process your request. To obtain this form or obtain more information concerning this process, please contact the privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list(for example, on paper or electronically.) The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs for providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

<u>Breach Notification</u> You have the right to be notified if your protected health information is breached, unless it is determined through our risk-assessment review that the impermissible use or disclosure posed not significant risk of "financial, reputational, or other harm" To you. Our privacy officer is Tammy Buehler, who can be reached at 1021 Eisenhower or by calling 620-792-5437.

<u>Complaints</u> You may complain to us or the Secretary of Health and Human Services if you believe your privacy right s have been violated by us. You may file a complaint with us by notifying our privacy contacting of your complaint. **<u>You will not be penalized for filing a complaint.</u>**

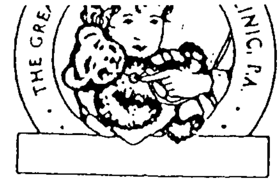
This notice was published and becomes effective on/or before <u>April 13, 2003. this notice was updated as of 12/31/13.</u>

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 620-792-5437.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name__________________________ **Signature**____
Date____________________ **Child's Name**______________________________________

Parent or Legal Guardian Statement of Permission to Treat



I, ______________________________, give my permission for

(child's name) ____________________________ to be examined, diagnosed, and treated for any medical condition which exists or is suspected to exist. This permission includes this and any subsequent visits for which I bring my child to this office. My permission also extends to releasing this medical record to consultant physicians if ever required to adequately diagnose and treat this child. From time to time, photographs which help to document significant medical conditions may be necessary and useful and I give my permission for such photographs to be taken. I consent to the administration of medications by oral, rectal, intramuscular, intranasal, subcutaneous, intravenous, intrathecal, or transdermal routes that may be required to treat my child's medical condition.

Signature____________________ Relationship________________

Patient's Name: ____________________ Medicaid#: ______________________

Advance Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services:

Items or Services:

- Inpatient newborn care
- Inpatient or outpatient hospital care
- Neonatal follow up visits
- Office visits for a sick child
- Well child exams
- Emergency care
- Lab tests, Immunizations, Allergen Injections
- Other

Because:

- Beneficiary was not eligible when services were provided
- Beneficiary was eligible when services were provided but did not inform the provider of KMAP eligibility timely.
- Medicaid does not cover the services

You may have received medical care from our doctors at the hospital or emergency room prior to coming the Great Bend Children's Clinic

This constitutes advance notice to you, the beneficiary that if all program requirements are met by (the provider) and payment is not made by Medicaid, that you may be held responsible for the charges if your services are not covered by Medicaid.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Please read this entire notice carefully.

- Ask us to explain if you don't understand why Medicaid probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost $______), in case you have to pay for them yourself or through other insurance.

I understand that I may be responsible for payment of medical services rendered by providers at the Great Bend Children's Clinic and/or hospital facility.

______________________________ ______________________

Signature of parent/guardian Date