

**BOWLING GREEN INTERNAL MEDICINE AND PEDIATRICS ASSOCIATES  
TREATMENT AUTHORIZATIONS AND FINANCIAL POLICIES**

Patient: \_\_\_\_\_

**FINANCIAL POLICY FOR PATIENTS**

Effective July 10, 2000 our office has established specific financial policies in reference to services rendered by Bowling Green Internal Medicine and Pediatrics, Associates. Our office does not accept walk in appointments. Appointment times over 20 minutes late will have to be rescheduled for another date and time. The financial policies are as follows:

**MEDICARE PATIENTS**

On January 1<sup>st</sup> of each calendar year Medicare requires that a \$150.00 deductible be satisfied prior to benefits being paid at 80% of the reasonable and customary amount. If you have not met your deductible prior to your office visit you will be responsible for your charges until your deductible is met. Once the deductible is satisfied you will be responsible for 20% of your charges. The only exception to this is a secondary supplemental plan that would cover the 20% of your charges. Please present all insurance cards to the front office upon your initial visit so this can be identified. If our office is aware that certain services are considered non-covered by Medicare, you will be asked to sign an Advance Beneficiary Notice that we informed you of any non covered service and your financial responsibility.

**MEDICAID PATIENTS**

You must have your Medicaid card available upon each visit to the office so that we can verify eligibility for that time period. If you do not have your Medicaid card available your appointment will have to be rescheduled for another date and time.

**COMMERCIAL INSURANCE PATIENTS**

Upon your initial visit to our office please present your insurance card. Our office will call your insurance to verify coverage and eligibility. You will be responsible for any applicable deductibles, co-pays and non-covered services that are required to be paid at the time of service. Insurance claims are billed to your insurance company as a courtesy; however, it is your responsibility to understand your insurance benefits as well as how your insurance processes and claims your claims.

**SELF-PAY PATIENTS**

Our office does not accept new self-pay patients unless approved by the physician and prior arrangements have been made. Payment will be required at the point of service.

**WORKMAN'S COMPENSATION**

Any patient being seen for a work related injury must have prior written approval from the workman's compensation carrier prior to being seen. Our office must be able to verify the reason for the visits as well as coverage for the date of service. The information should include the insurance company name, address, phone number, adjuster's name, injury date and workman's claim number. We cannot schedule the patient without this information. Failure to present this information on the day of the visit will result in rescheduling the visit for another date and time.

**THIRD PARTY LIABILITY CLAIMS**

Third party liability claims will be considered on a case-by-case basis. Prior to the visit in our office we will require all necessary billing information in writing. This information will include the names of all involved parties; complete insurance information, adjusters name and claim number if applicable. If you have attorney representation this information must also be provided.

**REFERRALS**

Please be aware of our office policy in reference to referrals. If your insurance company requires a referral when seeing another physician or specialist, please allow us 7 days notice to prepare your referral form for a non-emergency visit. If the 7 day notice is not received or another physician's office calls the day of the appointment, in a non emergency situation, the referral will be denied and you will be responsible for the visit. All non-emergent referrals will be done on the Monday prior to your visit with the other physician or specialist. All emergency referrals will be handled on a case-by-case basis. Please notify the office as soon as possible in an emergency situation. As a courtesy, we would like to inform you that various insurance companies will not allow us to do a back dated referral. It is very important that you keep us informed when a referral is needed for any reason. It is the responsibility of the patient, or insured if a minor child is involved, to inform our office if a referral is needed due to the various number of insurance companies and policies that have different levels of benefits.

**This financial policy will be strictly adhered to with the only exceptions being when prior arrangements have been made. Please direct any billing questions to the billing supervisor or the office manager.**

\_\_\_\_\_  
Signature Responsible Party or Parent of Minor Child Signature

\_\_\_\_\_  
Date

**AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT**

I hereby authorize S. Augusta Mayfield, MD, and/or Paul Kniery, MD, and/or Kelly Kries, MD, and /or Kevin Kelly, MD, and/or Christopher Goodwin, to administer such anesthetics and/or Medications and to perform such operations and/or procedures, and to admit to such hospital as may be deemed advisable in diagnosis and treatment of this patient. I have custody and/or responsibility for this patient and I have read the above and understand fully the contents thereof.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize payment of insurance benefits to be made directly to S. Augusta Mayfield, MD, and/or Paul Kniery, MD, and/or Kelly Kries, MD, and /or Kevin Kelly, MD, and/or Christopher Goodwin, for services rendered. I also hereby authorize S. Augusta Mayfield, MD, and/or Paul Kniery, MD, and/or Kelly Kries, MD, and /or Kevin Kelly, MD, and/or Christopher Goodwin, to release records pertinent to my care to referring physicians, and other healthcare facilities and my insurance company.

***This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.***

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**HIPAA**

By signing this form, you consent to our use and disclose of protected health information about your for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that the HIPAA policy is posted in both lobbies and a copy will be made available to me upon my request.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

**BOWLING GREEN INTERNAL MEDICINE AND PEDIATRIC ASSOCIATES  
REGISTRATION FORM**

**PERSONAL INFORMATION**

Date: \_\_\_\_\_ Physician: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
CITY ST ZIP

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May we leave a message: Yes \_\_\_ No \_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Address: \_\_\_\_\_  
CITY ST ZIP

Other Responsible Party: \_\_\_\_\_  
(Please provide if parents are divorced or separated.)

Address: \_\_\_\_\_  
CITY ST ZIP

Guardian Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
CITY ST ZIP

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

# **LEAD AND TB QUESTIONNAIRE**

Patient Name:

## **Lead Questionnaire:**

Yes \_\_\_ No \_\_\_ 1) Does your child live in or regularly visit a house or child care facility built before 1950?

Yes \_\_\_ No \_\_\_ 2) Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled?

Yes \_\_\_ No \_\_\_ 3) Does your child have a sibling or playmate who has or did have lead poisoning?

## **TB Questionnaire:**

Yes \_\_\_ No \_\_\_ 1) Was your child born outside the United States? Are there close contacts to the child who was born outside the United States?

Yes \_\_\_ No \_\_\_ 2) Has your child been in close contact with someone diagnosed with tuberculosis or has a positive skin test for tuberculosis?

Yes \_\_\_ No \_\_\_ 3) Does your child frequently traveled outside the United States? If "yes" what country?  
\_\_\_\_\_

Yes \_\_\_ No \_\_\_ 4) Is anyone in the child's household HIV-infected, or have a history of incarceration or use illicit drugs?

Patient Name:  
DOB:

Date:  
Physician:

### Family History

Father	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Mother	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Paternal Grand Father	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Paternal Grand Mother	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Maternal Grand Father	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Maternal Grand Mother	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Paternal uncle	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Paternal aunt	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Maternal uncle	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Maternal aunt	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Siblings	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure
Children	<input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Depression <input type="checkbox"/> Seizure

# RSV RISK ASSESSMENT

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GESTATIONAL AGE (GA): \_\_\_\_\_ weeks BIRTH WEIGHT: \_\_\_\_\_ (kg)

REGIONAL RSV SEASON START DATE: 10/01/2007 (May Vary by Payer)

1. Will patient be less than 2 years of age at the start of the season (Born after: 10/01/2005)?  Yes  
Proceed to Question #2  No  
Proceed to Question #3
2. Does patient have Chronic Lung Disease (CLD/BPD), hemodynamically significant Congenital Heart Disease (CHD), or other serious condition that compromise pulmonary or immune function (other than prematurity)?  Yes  
Proceed to Question #3  No  
Proceed to Question #3
3. Was patient born prematurely (<36 weeks' GA)?  Yes  
See prematurity section  No  
See prematurity section

<p style="text-align: center;"><b>&lt;28 Weeks Gestational Age</b> Less than 1 year old at the start of the season (Born after: 10/01/2006)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p style="text-align: center;"><b>29-32 Weeks Gestational Age</b> Less than 6 months old at the start of the season (Born after: 04/01/2007)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p style="text-align: center;"><b>32-35 Weeks Gestational Age</b> Less than 6 months old at the start of the season WITH additional risk factors (check all that apply) (Born after: 04/01/2007)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> Yes</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> School-age siblings</li> <li><input type="checkbox"/> Daycare attendance (&gt;2 unrelated children for &gt;4 hours per wk<sup>1</sup>)</li> <li><input type="checkbox"/> Exposure to environmental air pollutants</li> <li><input type="checkbox"/> Severe neuromuscular disease</li> <li><input type="checkbox"/> Congenital abnormalities of the airways</li> </ul> </div> <div style="width: 45%;"> <p><input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Low birth weight (&lt;2500 grams)</li> <li><input type="checkbox"/> Crowded living conditions</li> <li><input type="checkbox"/> Multiple birth</li> <li><input type="checkbox"/> Family history of asthma</li> <li><input type="checkbox"/> Other _____</li> </ul> </div> </div> <p style="text-align: center;"><b>Risk factors may change over time and may need to be reassessed.</b></p>	

\* This form is intended for use in assessing infants for risk of acquiring severe RSV disease. The form has been provided as a guide. This is not intended to be a substitute for or an influence on the independent medical judgment of the physician.

1. References available upon request

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SSP06-054B

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_