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New Patient Information

Name (Last, First, MI):_____**D.O.B:**_____ **Sex:** _____
Address: _____ Phone #: _____
Social Security Number: _____ Student: Yes/No Name of School: _____
Provider: _____ Primary Language: _____
Email: _____
*Ethnicity: _____ * Race: _____

Primary Insurance:

Policy Holder's Name: _____ Policy Holder's DOB: _____ Policy Holder's Sex: _____
Policy Holder's Social Security #: _____
Insurance Carrier: _____ ID #: _____ Group #: _____
Group Name: _____

Secondary Insurance/Medicaid:

Policy Holder's Name: _____ Policy Holder's DOB: _____ Policy Holder's Sex: _____
Policy Holder's Social Security #: _____
Insurance Carrier: _____ ID #: _____ Group #: _____
Group Name: _____

Emergency Contact Information:

Name (Last, First, MI): _____
Street Address: _____ ***Birthdate:*** _____
City, State & Zip: _____
Home Phone: _____ ***Home Email:*** _____
Work Phone: _____ ***Occupation:*** _____
Cell Phone: _____ ***Employer:*** _____
Relationship to Pt(s): _____
Lives with Patient? Yes/No

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Phone #: _____
Pharmacy Address: _____

***Preferred Method of Contact:** ☐ **Email** ☐ **Text** ☐ **Phone** ***Preferred Number:** ☐ **Home** ☐ **Cell** ☐ **Work**

Please note: Ideally, we prefer to contact parents/patients via email for appointment reminders and general information unless otherwise specified. If you wish to be contacted by other means, please indicate on the form.

Doctors/Providers

Augusta Mayfield, MD; Paul Kniery, MD; Kelly Kries, MD; Casey Miles, MD;
Ashley Parrigin, APRN; Kyla Byard, APRN; Jenna Tarter, APRN

(*) Indicates optional information requested under the Affordable Care Act, including **Ethnicity** (Hispanic or Non-Hispanic) and **Race** (Caucasian, Hawaiian, Pacific Islander, African American, American Indian, Alaskan, Asian)

Guarantor is the contact with financial responsibility for medical care

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Social History

Do you smoke tobacco products? If yes, how many cigarettes per day?			O Yes	O No
O 1-10	O 11-20	O 21-30	O 31-40	O 40+
Do you use recreational drugs?			O Yes	O No
Do you exercise regularly?			O Yes	O No
Are there smoke detectors in your home?			O Yes	O No
Do you drink caffeinated beverages?			O Yes	O No
Do you have children in daycare?			O Yes	O No
Do you drink alcohol?			O Yes	O No
Are you sexually active?			O Yes	O No
Have you traveled outside the U.S. in the past 6 months?			O Yes	O No
Lives with:	O Spouse	O Children	O Parents	O Other
Marital Status:	O Single	O Married	O Divorced	O Widowed

Past Medical History

Arthritis	O Yes
Asthma	O Yes
Depression	O Yes
Diabetes I	O Yes
Diabetes II	O Yes
Frequent Ear Infections	O Yes
Frequent Sinus Infections	O Yes
Headache	O Yes
High Blood Pressure	O Yes
High Cholesterol	O Yes
Hyperthyroidism	O Yes
Personal History of Cancer	O Yes
Personal History of Heart Disease	O Yes
Seasonal Allergies	O Yes

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Family History

Paternal Grandfather	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Paternal Grandmother	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Maternal Grand Father	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Maternal Grand Mother	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Siblings	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Children	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Father	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Mother	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Maternal uncle	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Maternal aunt	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Paternal Uncle	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure
Paternal Aunt	O Asthma	O Blood Clots	O Cancer	O Depression	O Allergies
	O Diabetes	O Heart Disease	O High Cholesterol		O Seizure

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Patient Authorization

Please read, initial, and sign below.

(Initial) _____ **Financial Policy:** I acknowledge that I received, reviewed, and agree to comply with the most recent version of the Bowling Green Internal Medicine & Pediatric Associates Financial Policy dated February 19, 2018.

(Initial) _____ **Financial Responsibility:** I understand that I am ultimately responsible for payment on my account, my child's/children's account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial) _____ **Insurance Coverage:** I understand that I am responsible to provide Bowling Green Internal Medicine & Pediatric Associates with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that Bowling Green Internal Medicine & Pediatric Associates will not retroactively file claims due to my failure to provide current insurance information.

(Initial) _____ **Assignment of Benefits:** I hereby authorize payment directly to Bowling Green Internal Medicine & Pediatric Associates, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Bowling Green Internal Medicine & Pediatric Associates, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

(Initial) _____ **Privacy Policy:** I acknowledge that I received, reviewed, and agree to comply with the Bowling Green Internal Medicine & Pediatric Associates Privacy Policy.

(Initial) _____ **Immunization Policy:** I acknowledge that I received, reviewed, and agree to comply with Bowling Green Internal Medicine & Pediatric Associates Immunization Policy.

(Initial) _____ **Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that providers of Bowling Green Internal Medicine & Pediatric Associates believe are necessary for me or my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment as long as I/we are patient(s) in this practice.

(Initial) _____ **E-Prescribing:** I voluntarily authorize Bowling Green Internal Medicine & Pediatric Associates to allow E-Prescribing for patient's prescriptions, while allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as I/we are patient(s) in this practice.

(Initial) _____ **HIPAA:** By signing this form, you consent to our use and disclose of protected health information about you 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 (HIPAA). I understand that the HIPAA policy is posted in both lobbies, and a copy will be made available to me upon my request.

(Initial) _____ I understand I can withdraw my consent at any time by contacting Bowling Green Internal Medicine & Pediatric Associates in writing at 615 7th Avenue Bowling Green, KY 42101.

Patient Name: _____ DOB: _____

Patient/Parent/Guardian Name (Print): _____

Patient/Parent/Guardian Signature: _____ Today's Date: _____

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Financial Policy

Effective February 19, 2018

Thank you for choosing Bowling Green Internal Medicine & Pediatric Associates as your health care provider. We appreciate your trust in us and the opportunity to care for you.

Our office does not accept walk in appointments. Appointment times over **20 minutes** late will have to be rescheduled for another date and time.

Our office and physicians make a great effort to get insurance companies to pay their share of the cost of this care in a timely manner. However, due to the recent changes brought on by the Accountable Care Act, this is becoming more challenging. We have therefore implemented a new Financial Policy; please read and sign the policy acknowledgement form. If you have any questions, please ask to speak with the Office Manager.

Patient Payments

Payment (co-payments or co-insurance) is due at the time of service. If you have an outstanding balance, please make sure whoever accompanies that patient to the visit is prepared to pay it. We accept cash, check, or credit/debit card to pay your account.

Medicare Patients

On January 1st of each calendar year Medicare requires that a $183.00 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.

First Statement

Your insurance policy is a contract between you and your insurance company. This contract requires that we collect certain co-payment or prepayment amounts depending upon the type of insurance and insurance carrier at the time of service.

Regardless of your insurance status, when we determine that you owe a balance, we will mail a statement to the mailing address provided to us by you. If your address changes, you are responsible for notifying us. All statements are also available on our secure patient portal. Payment is due upon receipt of the statement.

Please contact our office as soon as possible after receipt of your statement should you have any questions, or should you wish to discuss the outstanding balance. Should you need it, we can help you set up a payment plan with a valid credit card. The credit card use will automatically be charged a monthly basis. We require payment plans to be arranged before your bill is 30 days old. If your insurance pays us after that time, you will be reimbursed.

Prompt Pay Discount

Bowling Green Internal Medicine & Pediatric Associates provides a prompt pay discount to those uninsured patients who pay for services at the time of service, thereby avoiding billing and collection costs by the practice. These discounts are set at 25% off the retail price of an office visit. Discounts do not apply to any services other than office services. Prompt pay discounts are not offered to insured patients where Bowling Green Internal Medicine & Pediatric Associates is contractually required to accept a specific fee schedule. However, we do everything we can to mitigate the expense of anyone who is underinsured.

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Subsequent Statements and Unpaid Balances

If your account remains unpaid, subsequent statements will be sent to the address we have on file. When your balance is 75 days past due your account will be frozen and turned over to an outside collection agency for non-payment. Once the account is paid or payment arrangements are made through the collection agency, your account will be un-frozen.

Insurance Coverage

While we make a good faith effort to verify your insurance coverage, we are not liable to guarantee that the information given to us by your insurance is correct. It is your responsibility to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services and work with us to make sure that these services are provided at the most cost-efficient manner.

I agree to provide Bowling Green Internal Medicine & Pediatric Associates with the most current and accurate insurance information as it applies to me or my child's account. I will notify the office of any changes to insurance and agree to the assignment of benefits. Finally, if insurance information you provide delays payment, you will be asked to pay in full billed charges and seek reimbursement from your insurance provider directly. The insurance company gives us a very small window in which to file a claim, and incorrect insurance information usually delays this beyond their window.

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. 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 numbers of insurance companies and policies that have different levels of benefits.

Child Advocacy

As an advocate for our young patients, Bowling Green Internal Medicine & Pediatric Associates will not intervene in any custody dispute or financial responsibility dispute between parents or other responsible parties. We will send statements to any one address provided; however, we cannot look to more than one party for financial responsibility.

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak with the Office Manager if you have any questions, comments, or concerns. We thank you for your support and look forward to serving you in the future.

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Immunization Policy

At Bowling Green Internal Medicine & Pediatric Associates we are dedicated to providing the highest quality of evidence-based medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP).

These well-respected organizations and committees include panels of experts in pediatrics as well as infectious disease. The goal is to eliminate or minimize preventable serious disease, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable disease, and analyze reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect your child. Be aware that there are vaccines used in other countries that are not routinely used in the United States to protect those children from even more diseases.

At Bowling Green Internal Medicine & Pediatric Associate we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, we feel that this decision not only puts your child at risk of serious preventable disease, but also contributes to the health risk of others.

Please be advised that if you desire an "alternate" vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of Bowling Green Internal Medicine & Pediatric Associates, the AAP, the AAFP and the ACIP. Because we believe that this decision puts your child at risk for vaccine preventable disease and increases health risks for others, Bowling Green Internal Medicine & Pediatric Associates respectfully declines to be your children's pediatricians.

Thank You.

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No-Show Policy

Quality care for our patients is our priority. No-Shows and excessive last-minute cancellations have a negative impact on the efficiency of our practice, can potentially jeopardize the health of our patients, and is a disruption to the patient flow and scheduling availability. Scheduled appointments represent an agreement between you and your physician. Patients are expected to regularly attend scheduled appointments.

Although there are sometimes emergencies that require our immediate attention or appointments that take longer than expected, we do not “double” or “triple” book our appointment slots. If you schedule an appointment and fail to keep it or fail to give adequate notice so another patient may be placed in that appointment slot, it prevents another patient, who may need an appointment that day from being able to be seen in a timely fashion. As a courtesy to you, we have reminder calls and/or texts 2 to 3 days prior to your scheduled appointment.

Please note the following:

1. Please be aware that if you are a new patient and fail to show up for your 1st appointment without giving at least a 24 hour notice, you may be asked to find another medical office or physician for medical care.

2. For Well Child Check-up appointments that must be cancelled, please give at least a 24-hour notice prior to the appointment time. All sick or recheck appointments that must be cancelled, please give at least a four-hour notice.

3. All “no show” appointments will be documented in the patient’s chart and should you have excessive no shows for appointments, the physicians may request that you see another physician to care for you.

4. Missed multiple sibling check-ups (2 or more children in the same family scheduled on the same day) may forfeit the opportunity to schedule more than one child on the same day in the future for their well checkups. We understand that emergencies may occur, and should that be the case, please contact us as soon as possible to let us know your situation. This goal of this policy is to improve scheduling opportunities and increase availability for all our patients.

Acknowledgement of Receipt-*I have received and read a copy of BGIMPA’S No-Show Policy.*

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Printed Name of Patient/Parent/Guardian

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