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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: _____ Lives w/Parent/Guardian: _____
*Ethnicity: _____ * Race: _____
Guarantor_____ Patient Portal Email: _____

Primary Insurance:

Policy Holder's Name: _____ *Policy Holder's D.O.B.:* _____ *Policy Holder's Sex:* ____
Policy Holder's Social Security #: _____
Insurance Carrier: _____ *ID #* _____ *Group #* _____

Secondary Insurance/Medicaid:

Policy Holder's Name: _____ *Policy Holder's D.O.B.:* _____ *Policy Holder's Sex:* ____
Policy Holder's Social Security #: _____
Insurance Carrier: _____ *ID #* _____ *Group #* _____

Contact Information (Complete all items for parents, only bold items for other authorized contacts):

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

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: _____

Doctors/Providers

Augusta Mayfield, MD; Paul Kniery, MD; Kelly Kries, MD; Casey Miles, MD; Helen Carter, MD; Ashley Parrigin, APRN; Emily Cope, 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, Black, American Indian, Alaskan, Asian)

Guarantor is the contact with financial responsibility for medical care

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Responsible Party:

_____

Name (Please print) Signature Date

If parents are divorced or separated, please fill out this section:

Who has primary custody? _____

Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ **Yes** ☐ **No**

If Yes, please explain and provide a copy of any legal paperwork that supports this restriction:

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RSV Risk Assessment-SEASON START OCTOBER

Patient's Name: _____ Date: _____

Date of Birth: _____ Gestational Age (GA): _____ Birth Weight: _____ (kg)

1. Will patient be less than 2 years of age at the Start of the season (Born after: 10/31/2018)?
   ☐ Yes ☐ No
   Proceed to Question #2

2. Does patient have Chronic Lung Disease (CLD/BPD), hemodynamically significant Congenital Heart Disease (CHD), or other serious conditions that compromise pulmonary or immune function (other than prematurity)?
   ☐ Yes ☐ No
   Proceed to Question #3

3. Was patient born prematurely (≤35 weeks' (GA)?
   ☐ Yes ☐ No
   See Table Below

≤ 28 Weeks Gestational Age	29-32 Weeks Gestational Age
Less than 1 year old at the start of the season (Born after: 10/31/2019)	Less than 6 months old at the start of the season (Born after: 04/30/2020)
❒ Yes ❒ No	❒ Yes ❒ No

32-35 Weeks Gestational Age

Less than 6 months old at the start of the season WITH additional risk factors[1] (check all that apply)
(Born after: 07/31/2020)

❒ Yes ❒ No

Daycare attendance	Low birth weight (<2,500 g)
(Definition: >2 unrelated children for >4 hr/week	Multiple birth
School age siblings	Exposure to environmental tobacco smoke
Exposure to environmental air pollutions	Crowded living conditions
Severe neuromuscular disease	Family history of wheezing
Congenital abnormalities of the airways	Young chronological age (≤12 weeks)

Other _____

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

[1] References available upon request

SYN08-067O

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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: _____

Siblings: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Patient/Parent/Guardian Name (Print): _____

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

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Patient Name: _____ Date: _____

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of _____ authorizes the person(s) listed below to
(Child's Name)

consent to treatment of the child, including, but not limited to, labs, vaccines/injections, referrals, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____ (Phone Number).

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

Name: _____Relationship to Child: _____Phone:_____

Name: _____Relationship to Child: _____Phone:_____:

Name: _____Relationship to Child: _____Phone:_____:

2. Medical concerns: _____

3. Known allergies: _____

Name of Parent or Legal Guardian: _____Relationship to Child: _____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

Signature: _____ Date: _____

Witness: _____ Witness Signature: _____

This Consent is effective until withdrawn in writing by the child's parent or guardian.

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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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Ashley Parrigin, APRN · Emily Cope, APRN · Kyla Byard, APRN · Jenna Tarter, APRN

Appointment Policy

It is our intention to provide you with the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review policies that affect the way services are provided.

In the Office

- **Arrive early.** Please remember that all insurance requires that your insurance data be updated prior to each encounter. This usually takes a few minutes. If this is not done, your insurance may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.

- **Schedule an appointment by calling 270-846-4800 or visit our website to schedule your OWN same day SICK appointment.**

- **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your visit.

- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your appointment and to minimize the need to reschedule.

- **Late arrivals (>15 minutes after scheduled appointment) will be offered the next available appointment.** While we will do all that is possible to accommodate requests, the first-available appointment may or *may not* be on the day the appointment was missed.

- **Cancellations/No Show Policy.** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

    - A "No Show" is someone who misses an appointment without canceling it within a 24-hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

Bowling Green Internal Medicine & Pediatric Associates
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Phone: 270-846-4800
Fax: 270-846-4828

Authorization to Disclose Protected Health Information

This form is for all record requests.

RELEASE INFORMATION FROM:
Specify Provider/Organization Name and Facility Address

Organization Name: _____

Address: _____

_____

_____

RELEASE INFORMATION TO:
Specify Provider/Organization Name and Facility Address

Organization Name: B.G. Internal Medicine & Ped.

Address: 615 7th Ave

Bowling Green KY 42101

_____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH ____/____/_____ **SSN/MEDICAL RECORD #** _____

ADDRESS _____
Mailing Address, City, State, Zip

_____

Covering the period(s) of health care:

FROM (Date) ____/____/_____ **TO** (Date) ____/____/_____

1. **Information authorized for disclosure**, *if included in my records*:
   - ☐ Complete Health Record
   - ☐ Visit/Discharge Summary
   - ☐ Clinical Documentation of Physical
   - ☐ Documentation of Consultation
   - ☐ Immunization Records
   - ☐ Progress Reports
   - ☐ Radiology and Diagnostic Imaging Reports
   - ☐ Photographs, Videos, Digital or Other Images
   - ☐ Pathology Reports

FORM Js

☐ Laboratory tests *(please specify*)

☐ Other *(please specify)*

2. ***If applicable,* I also give permission** for the following "Sensitive Protected Health Information" to be disclosed ***(please initial below):***

☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)

☐ Behavioral Health Services / Psychiatric Care

☐ Treatment for Alcohol and/or Drug Abuse

☐ Sexually Transmitted Diseases (STD)

☐ Genetic Counseling / Testing

_____ Initial **I understand** that the information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. **The purpose for which disclosure is authorized** *(check where applicable)*:
☐ Medical Care ☐ Insurance ☐ Benefit eligibility ☐ Immunization

Other: _____

4. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

(Date) / / . **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such,** (Initial here _____) **it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

5. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signed: Patient – (or Legal Representative, Parent or Legal Guardian) *(Relationship if not Patient)*

ID Provided _____ Date ____/____/_____

_____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or court.

Official Use Only
Name/Title of Person Releasing Information: _____
Date ____/____/_____

FORM Js

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Patient Portal?

In an ongoing effort to support our parents and patients, we encourage you to register on the ***Patient Portal.*** *The portal provides parents a secure link to health records and the ability to communicate with us on a variety of healthcare needs. Please refer to our website (www.bgimp.com).*

To register and take advantage of everything the portal has to offer, please visit our website and click on the link to request your patient portal account, or let the front staff know.

We will complete the registration process and email a temporary password to you. When you log on, the system will prompt you to create a more personalized and secure password. Please note that usernames and password are case sensitive.

Access to a number of health-related services is now available to include:

- *Viewing/printing immunizations*
- *Viewing/printing recent visits*
- *Email reminders*
- *Access to statements*
- *Maintaining demographic information*
- *Lab results*
- *Prescription refills*
- *Digitally complete required questionnaires prior to your visit*
- *Online access to secure messaging to your provider*

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Preventive Health Care and Sick Visits

Good health care for newborns, infants, children, and adolescents begin with the preventive visit (checkup) and other services that help keep you healthy. These are preventive services. Our doctors and staff provide these services based on a plan called Bright Futures. The American Academy of Pediatrics (AAP) made this plan to help doctors and families know what preventive services children should receive from birth to 21 years of age, such as screening tests, and advice about staying healthy and safe. This plan can be altered to suit each child as needed. We also follow the AAP vaccine schedule for newborns, infants, children and adolescents.

Because preventive services are important to keeping children healthy, the Patient Protection and Affordable Care Act (health care form law) includes a rule that all preventive screenings and services included in the Bright Futures plan and vaccine schedule must by covered by most health plans. This is not always true, though, as some older plans, called grandfathers plans, do not have to pay in full for preventive services.

Health Plan Terms to Know
Co-payment: A fixed amount that you pay for certain health services before the health plan pays
Coinsurance: The portion of the charge that is not paid the health plan (usually a fixed percent of each amount paid by the plan).
Deductible: An amount that must be paid before the health plan pays for covered services.

There may also be times when a child needs a service that is not considered preventive on the same day as a well-child visit. If a child is not well or a problem is found or needs to be addressed during the checkup, the physician may need to provide an additional office visit service (called a *sick visit)* to care for the child. This is a different service and is billed to your health plan in addition to the preventive services provided on that day. *If you have a co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.*

We value your time and want to make the most of each appointment for the child. This is why we will address any problem that needs a doctor's care during well-child visits so that only one trip is needed. Some services that may be provided and billed in addition to preventive services include:

- The doctor's work to address more than a minor problem, which will be billed as an office visit (e.g. if the doctor gives a prescription, orders tests, or changes care for a known problem)
- Medical treatments (e.g. breathing treatments)
- Any surgery (e.g. removing splinters or something the child put in his or her nose or ear)
- Tests performed in the office that are not included in the Bright Futures plan

Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services provided. Please feel free to ask questions about services that may not be paid in full by your health plan on the day of your visit. It is our pleasure to help.

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Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bowling Green Internal Medicine and Pediatric Associates may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Bowling Green Internal Medicine and Pediatric Associates has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Bowling Green Internal Medicine and Pediatric Associates will provide me with the most current *Notice of Privacy Practices*.

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting BG Internal Medicine & Pediatric Associates at 615 7th Avenue Bowling Green, KY 42101, phone 270-846-4828 or www.bgimp.com.

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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