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:

Please list below all siblings that are current patients at BGIMP.

Name: ____ **Date of Birth:** ____________________________

Name: ____ **Date of Birth:** ____________________________

Name: ____ **Date of Birth:** ____________________________

Name: ____ **Date of Birth:** ____________________________

Name: ____ **Date of Birth:** ____________________________

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: _______________________

615 7th Avenue · Bowling Green, KY 42101
Phone: (270) 846-4800 · Fax: (270) 846-4828

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.

Patient Copy

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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

615 7th Avenue · Bowling Green, KY 42101
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