

MRN \_\_\_\_\_

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_ (Jr/Sr/III etc.)

Male  Female Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Preferred Language:  English  Spanish  Other \_\_\_\_\_ Need Interpreter  Yes  No

Ethnic Background:  Hispanic/Latino  Not Hispanic/Not Latino  Other \_\_\_\_\_

Race:  Ame. Indian/Alaska Native  Asian  Black/African American  White/Not Hispanic  Other \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

**Parent/Guardian Information/Responsible Party Information**

**MOTHER**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_ (Jr/Sr/III etc.)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ ext. \_\_\_\_\_ Cell phone \_\_\_\_\_

Mother's E-mail Address \_\_\_\_\_ Mother's DOB: \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

**FATHER**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_ (Jr/Sr/III etc.)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ ext. \_\_\_\_\_ Cell phone \_\_\_\_\_

Father's E-mail Address \_\_\_\_\_ Father's DOB: \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Emergency Contact Other Than Responsible Party**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Primary Insurance**

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male  Female Soc Sec. # \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

**Secondary Insurance**

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male  Female Soc Sec. # \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

I give my permission to release my child's immunization record to his/her daycare, school, camp, and/or sport program upon request.

Signature of parent/guardian/person authorized to sign for patient \_\_\_\_\_

Date \_\_\_\_\_



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Name of Baptist Facility: River City Pediatrics Address: 1717 W. Massey Rd, Memphis, TN 38120

PATIENT'S NAME:  BIRTH DATE:  Last 4 digits of SS #:

ADDRESS:  Phone #:

I authorize Baptist or the following person or organization (specify if applicable) River City Pediatrics to:

disclose my health information to: \_\_\_\_\_  
(Name and Address) - Specify: Attorney, Insurance, Self, etc

obtain/request copies of my health information from:   
(Name and Address) - Specify: Hospital, Doctor, etc

Purpose of use, disclosure, and or request:  Continuation of Care/Treatment  Attorney  At the request of the patient  
 Payment  Other, specify: \_\_\_\_\_

I authorize use and/or disclosure of information covering treatment from: \_\_\_\_\_ to: \_\_\_\_\_  
(enter specific dates)

Information to be used and/or disclosed:  
 Abstract (Example: History and Physical, Discharge Summary, Operative Report, and Pathology Report, if applicable)  
 Itemized bill  Radiology images  Emergency Department Record  Tracings or other graphic data  
 Monitor strips  Photographs/Videos  Secure Chat Text Messages  
 Outside Records  Other (Specify) \_\_\_\_\_

Method of Disclosure:  Paper  Compact Disc (CD)  Other: Email

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

This release will include information I have previously restricted from my health plan unless I initial here.

This authorization will expire one year from the date of your signature unless you specify a different expiration date, event, or condition.

Please specify: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.  
I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Director of Health Information Management at the Baptist facility indicated above. The revocation document is to contain the signature of the patient or patient's legal representative.  
I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may effect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.  
I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Baptist seeks an authorization for its own use or disclosure of protected health information (e.g., marketing, research, etc.), a copy of the authorization is provided to the patient.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient (or person authorized to consent for minor patient who is unable to sign)

\_\_\_\_\_  
Relationship and/or authority to act for the patient

Photo ID was provided: Yes  No  If no, specify form of patient identification: \_\_\_\_\_





ADMG

**I. GENERAL CONSENT TO TREATMENT AND TESTS:**

- A. I have been referred for care (treatment, testing or otherwise) at this Baptist facility (the facility). I permit my physicians, the facility and its employees and others involved in my care to provide such treatment, testing or care in ways they judge beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent. I consent to examinations, x-rays, blood tests, including blood tests for communicable diseases such as hepatitis and AIDS (including testing where health care personnel have been exposed to my blood and body fluids), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, radiation therapy and other services or treatments rendered or ordered by my physician, consulting physicians and their associates and assistants, or rendered by the facility's employees under the instructions, orders or direction of such physician(s). I understand that State law requires reporting of certain positive test results, such as hepatitis and the antibody for the AIDS virus, to the Health Department.
- B. If the facility participates in the training of medical students, interns, residents, fellows, or allied health care personnel, I consent to the observation of and participation in my care by such medical personnel in training.
- C. I acknowledge that the hospital in certain instances uses reprocessed devices (devices that are cleaned, disinfected or sterilized between uses) that are marketed by their manufacturers as "single use" devices, a practice that is permitted and regulated by the US Food and Drug Administration. I accept and consent to the use of these devices and supplies during any surgery and/or other procedure performed on me.
- D. I permit my physicians, the facility and its employees and others involved in my care to take photographs, film or videotape of me for clinical, performance improvement and/or risk management purposes. All such photographs, films or videotape shall become part of my medical record and subject to the privacy laws applicable to medical records.
- E. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my treatment, testing or other care.

**II. INDEPENDENTLY PRACTICING DOCTORS AND OTHER HEALTH CARE PROFESSIONALS:**

- A. I understand that my admitting and consulting physician(s), radiologist(s), pathologist(s), emergency department physician(s), anesthesiologist(s), podiatrist(s), psychologist(s), allied health professionals employed by physicians or other corporations and private duty nurses (and sitters) are engaged in the practice of their professions on behalf of themselves or other corporations and are not employees or agents of the facility. I understand that I may receive bills for their professional services in addition to bills I receive from the facility.
- B. I also understand that the facility permits various educational institutions to train medical students, interns, residents, fellows and other health care professionals at the facility. I consent to the observation and participation of all such personnel in my care. I understand and acknowledge that while these personnel practice on the facility's premises, use the facility's equipment, and are subject to the facility's administrative rules and protocols, they are NOT employees or agents of the facility. The facility is not responsible for their acts or omissions, and I will not attempt to hold the facility responsible for their acts or omissions. If I want to know the employment status/affiliation of any health care provider, I will ask questions to satisfy myself of their status sufficient to make informed decisions regarding the employment status/affiliations of the various health care providers.
- C. I understand that my physician(s) and other health care providers may have financial interests in various health care ventures. I understand that I have a right to question any health care professionals involved in my care about whether they have any such interests that might affect my care.
- D. I acknowledge that I may receive treatment from hospital-based physicians who do not participate in my insurance plan and that I may receive a separate bill from such physicians for the amount unpaid by my insurer.

**III. RELEASE FROM LIABILITY FOR LEAVING OR REFUSING CARE AGAINST MEDICAL ADVICE:**

I agree that if I leave the facility or refuse care against the advice of my physician or facility personnel, then the facility, its personnel, and my physician(s) are released from any responsibility or liability for any injuries or damages which may result from my leaving or refusing care.

**IV. FOLLOW-UP CARE REFERRAL:**

I understand that I have the right to choose the agencies that will provide any needed follow-up care, supplies or equipment. If I do not make a choice, I authorize the facility to make referral arrangements on my behalf, including referral to agencies affiliated with the facility.

**V. AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION:**

- A. I understand that my medical information may be maintained in an electronic medical record to enable Baptist facilities and care providers throughout this health care system to more readily obtain access to the information. I understand that I will receive a Notice of Privacy Rights from the facility that addresses the ways in which the facility may use my health information for treatment, payment, and health care operations purposes. Please acknowledge your receipt of the Notice of Privacy Rights on the reverse side of this form.
- B. I permit the facility to acknowledge that I am or have been a patient, unless I have specifically instructed the facility to withhold such information.
- C. I intend for this authorization to apply to my present, past, and future admission at Baptist facilities.
- D. I understand and agree to the presence of individuals from outside organizations in the patient care area if indicated while I am undergoing services at this facility.
- E. Third Party Liability/Workers Compensation: I authorize Baptist to disclose my entire medical record for today and any follow up visits related to the injury for which I am requesting treatment. Further, I understand that my employer's insurance company may request past visits as part of their investigation and discovery process to determine what workers compensation benefits I'm owed. The disclosure of my personal health information may include, but not be limited to, information regarding my diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV).
- F. Employment Screenings: I request and authorize Baptist to disclose my employment physical and/or drug screen results to my potential employer (for pre-employment screenings) or current employer (for random screenings, fitness for duty, etc). I understand that the disclosure of my personal health information may include, but not be limited to, information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV).
- G. I understand that I have the right to revoke any authorization provided under this Section V at any time, except to the extent that release of information has already occurred in reliance on my prior authorization. I understand that in order to revoke an authorization, a written document declaring the revocation must be delivered in person or by certified mail to the Director of Health Information Management at the Baptist facility indicated above. The revocation document must contain your or your legal representative's original signature. I understand that authorizing the disclosure of health information is voluntary and that I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as payment, enrollment or eligibility for benefits. My refusal to authorize release of my information may adversely affect payment for the services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form. I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.
- H. I understand that my bill may come from the facility or an affiliated Baptist entity or group.

**VI. FINANCIAL RESPONSIBILITY:**

The undersigned, jointly and severally, in consideration for the services rendered to the above named patient, accept financial responsibility and agree to pay in advance any applicable deductibles, copayments, coinsurance and estimated self-pay dollars and to pay in arrears the facility's and my physician's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agree that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance.



**GENERAL CONDITIONS CARE AND TREATMENT RECORD**

▼ Patient Label ▼



ADMGC

**VII. COMMUNICATIONS REGARDING MY ACCOUNT:** initial here: \_\_\_\_\_

I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

**VIII. ASSIGNMENT OF INSURANCE BENEFITS:**

- A. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, or under other insurance coverage, is correct. I request that payment of authorized benefits be made on my behalf to the facility and other providers.
- B. I transfer and assign to the facility and to my physicians and other providers and entities providing special services which may be covered by the third party payer, all of my rights to benefits payable to me or to a beneficiary under all applicable policies of insurance or health plan(s) listed with the facility at registration, and those not listed and which are later determined to provide coverage, but not to exceed the facility's or other providers' regular and customary charges for services. By this assignment, I authorize payment directly to the facility and directly to other providers and entities providing special services. I understand and agree that if any part of my account is not paid by insurance, for whatever reason, I am still financially responsible for the indebtedness. It is my responsibility to take the action necessary for such benefits to be paid to the facility and other providers.
- C. If a third party or his/her/its insurer is liable to me for my injuries and expenses, including my facility charges, I authorize and direct such third party and insurer to withhold from any settlement or judgment which I may recover, such sums as are due and owing to the facility for services rendered to me, and such sums are hereby assigned to the facility and are to be paid directly to the facility by such third party or insurer. I understand that I am fully responsible for the facility charges and this does not relieve me of my personal responsibility to pay the charges when due.

**IX. ORGAN DONATION:**

I understand I have the right to donate my organs.

**X. TISSUE DISPOSAL:**

I authorize the facility to retain or dispose of tissue removed from my body (including fetal or afterbirth tissue of obstetrics patients) in accordance with its usual procedures.

**XI. PERSONAL VALUABLES:**

I understand that it is my responsibility to arrange for the safekeeping of my money, jewelry, valuables, or other items of property and agree that the facility is not responsible or liable, directly or as an employer of others, for damage to or loss of money, jewelry, valuables or other items of personal property, regardless of the cost, unless I have deposited such items with the facility and the facility has agreed to hold the items for safekeeping. This release from responsibility includes any loss of or damage to dentures, bridgework, clothing, eyeglasses, contact lenses, prostheses, jewelry, money and all other items of personal property.

**XII. GENERAL INFORMATION AND AUTHORIZATION:**

- A. This is to certify that I have been given a copy of my rights and responsibilities as a patient in this facility.
- B. For Medicare beneficiaries admitted to the hospital: I have received a copy of the Important Message from Medicare.
- C. If my insurance requires admission or pre-admission certification, I understand it is my responsibility to complete this process or have my attending physician complete this process.

**(Mississippi Facilities Only):**

- D. I hereby authorize the facility to retire x-ray film and any other graphic data, which may be generated during my care (treatment, testing or otherwise) four years after the time generated if a proper report is in the medical record.
- E. For Medicaid obstetrical patients (Filing claims for Newborn; OBRA 90): Will the newborn child be in the household of the mother?  
YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_

**XIII. SEVERANCE OF INVALID TERMS:**

I understand that if any provision of this Agreement shall be prohibited by or be invalid under applicable law, such provision shall be ineffective to the extent of such prohibition and the remaining provisions shall remain effective and enforceable.

Please place your initials by the appropriate responses:

XIV. I permit the facility to acknowledge that I am a patient. YES \_\_\_\_\_ NO \_\_\_\_\_

**XV. Acknowledgement of Notice of Privacy Rights**

- \_\_\_\_\_ I received a copy of the Notice of Privacy Rights.
- \_\_\_\_\_ I previously received a copy of the Notice of Privacy Rights and understand that additional copies of the Notice are available for review.

I have read and understand this document and agree to its terms. I further acknowledge that I have been given the opportunity to 1) ask questions regarding my financial liability under this agreement and 2) ask for a determination if I qualify for financial assistance programs.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE/TIME

\_\_\_\_\_  
SIGNATURE OF GUARANTOR/RESPONSIBLE PARTY

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE/TIME

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE/TIME

For Facility Use Only:

If Acknowledgement of receipt of Notice of Privacy Rights not obtained, please note reason:

\_\_\_\_\_ Medical Emergency \_\_\_\_\_ Refused to Sign \_\_\_\_\_ Unable to sign because

Employee signature: \_\_\_\_\_

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



**GENERAL CONDITIONS CARE AND TREATMENT RECORD**

▼ Patient Label ▼



Clinic Location: RIVER CITY PEDIATRICS  
Address: 1717 W. MASSEY RD.  
MEMPHIS, TN 38120

Phone: 901-761-1280  
Fax: 901-761-9347

### Authorization for Non-Parental Consent

Name of Child: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Name & Address of Parent/Legal Guardian: \_\_\_\_\_

Name(s) & Address(es) of Individuals authorized to consent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

As the parent/legal guardian of the above named child, I hereby given my authorization to the above listed individuals to consent for medical treatment and sign all necessary paperwork for medical treatment for my child in my absence.

This authorization shall remain valid: *(please check one)*

- For as long as my child is receiving treatment at this physician office/clinic
- From \_\_\_\_\_ to \_\_\_\_\_  
*Date* *Date*

I understand that by giving my authorization for someone else to consent to treatment of my child, I am in no way relieving myself from my responsibilities and obligations as a parent. I understand that I will remain financially responsible for the care provided to my child. I agree to provide the individual I authorize to consent for treatment for my child with sufficient information about my child's health and my individual preferences for treatment to enable the authorized individual to provide this physician office/ clinic with adequate information to provide care for my child.

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

I understand that if I wish to revoke this authorization, I need to contact \_\_\_\_\_ at \_\_\_\_\_

## **Baptist Medical Group Inc. (BMG)**

### **Cancellations and Missed Appointments**

Our goal is to provide quality individualized medical care. "Late cancellations" and "No Shows" are barriers for individuals who need access to medical care in a timely manner. *We recognize that certain life events make it difficult to notify us of the need to cancel or reschedule an appointment.* If you must cancel an appointment, please follow the guidelines below.

#### **Cancellation**

In order to be respectful of the medical needs of other patients, please be courteous and notify the clinic when you are unable to show up for a scheduled appointment. We require that you notify the clinic 24 hours in advance. A late cancellation exists when notice to cancel does not occur 24 hours prior to the scheduled appointment time. This timely notification will allow another individual an opportunity to receive treatment.

\*Failure to cancel a scheduled appointment in a timely manner will be recorded in the medical record.

#### **How to Cancel Your Appointment**

To cancel appointments, please call BMG River City Pediatrics. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please include a telephone number. A clinic representative will contact you to schedule another appointment that better meets your needs.

If you have signed up for our web-based patient portal, MyChart, you may electronically cancel an appointment, request to reschedule, and/or sign up for "FastPass". FastPass is a wait list feature that automatically sends messages via text or email to notify patients of a "wait-list" appointment offering. Upon receiving the message, patients can then log in to MyChart and claim the available appointment, decline the appointment offering, or simply wait for another offering.

#### **Missed Appointment / No Show**

A no show exists if you fail to appear for a scheduled appointment. \*Failure to appear for a scheduled appointment is recorded in the medical record.

- Each missed appointment / no show will be followed up by a clinic representative.
- Three missed appointments and/or late cancellations may result in \$25.00 fees and/or separation from the clinic.

\*Please note: Missed appointments are reviewed over a 12 month period.

**I do hereby acknowledge that I have received and read the guidelines above and have had any portion of the guidelines, which I do not understand, explained to me.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

# BAPTIST MEDICAL GROUP

## AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_ (Jr/Sr/II etc.)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Home phone # _____ | <input type="checkbox"/> Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cell phone # _____ | <input type="checkbox"/> Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Work phone # _____ | <input type="checkbox"/> Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Which method of communication is preferred?  No contact  Mail  Phone  Email  Mychart

With whom may we share information about your health? Please list below.

**Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:**

1. Last 4 digits patient's social security number      2. Patient's date of birth      3. Patient's zip code

### AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment		May Discuss Billing Info	
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have a legal document that states who will make decisions if you are unable?  Yes  No

If yes, Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Check one:  Healthcare Proxy/Agent       General Power of Attorney       Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY – Document should be Scanned under Ambulatory Auth and Consent Doc type**

# BAPTIST MEDICAL GROUP

## PAYMENT POLICY

Payment is required at the time of service

**Self-Pay:** We require a minimum payment of \$177.00 at the time of each visit. Payment is to be paid in full if you have an outstanding balance. If labs or x-rays are taken you will be responsible for the amount. If you are a new patient, the first visit is \$188.00 plus any other tests possibly preformed during your visit.

**Deductible or High Deductible:** A deductible is the dollar amount you are responsible for before the insurance company begins to pay. Most deductibles cover a calendar year (Example: January 1<sup>st</sup> of each year, your deductible starts over).

If you have not met your deductible, we require you to pay \$150 towards your visit today as a Good Faith Deposit.

**Co-insurance:** Co-insurance is a percentage of covered services that you are responsible for paying. (For example, an insurance plan may have a 20 percent co-insurance for visits, so if the visit cost is \$277.00, you would pay \$55.00). Your insurance plan may have a co-insurance, co-pay, deductible, or all three.

**Co-payments:** A co-payment (co-pay) is a predetermined fee paid by the patient to the provider at the time service rendered. Each health insurance plan establishes these fees upfront. The fees are often printed on the insurance card.

**We cannot waive a co-payment, deductible, or co-insurance.**

Your insurance company establishes your plan payment specifics when you enroll. We are required to collect these at the time of service. This includes deductibles, co-pays, and co-insurance. If you are unable to make payment, arrangements should be made prior to you coming in for your appointment.

**If you need assistance regarding payment options, we can refer you to our BMG Central Business Office at (901) 226-3186 or toll free (877)348-1281.**

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