BAMA PEDIATRICS

920 Rose Drive
Northport, AL 35476

Date: ________________

Patient's Full Name: ____

Date of Birth: ______________________ **Age:** ________________ **Sex:** ____________

Social Security #: ____

Home Address: ____

City: ______________________ **State:** ________________ **Zip:** __________________

E-mail address: ____

Patient lives with: ______________ **Primary Contact #:** ______________ **Alternate #:** __________

Emergency Contact: ______________ **Relationship:** ________________ **Phone:** ____________

Whom may we thank for referring you to our office? ______________________________

Please circle appropriate answer below:

Ethnicity: Hispanic or Latino   Non-Hispanic or Latino   Unknown

Race: African American   Asian   Caucasian   Hispanic   Native American   Pacific Islander   Other: _______

Language: English   Spanish   German   Other: ________________

Mother   Step-Mother   Guardian (Circle One)

Name: ______________________________

DOB: ______________________________

Home Phone: ______________________________

Cell Number: ______________________________

Email Address: ______________________________

Employer: ______________________________

Social Security: ______________________________

Father   Step-Father   Guardian (Circle One)

Name ______________________________

DOB: ______________________________

Home Phone: ______________________________

Cell Number: ______________________________

Email Address: ______________________________

Employer: ______________________________

Social Security: ______________________________

Child's Primary Insurance

Insurance Company: ______________________________

Contract #: ______________________________

Group #: ______________________________

Policy Holder: ______________________________

Policy Holder DOB: ______________________________

Relationship to Child: ______________________________

Child's Secondary Insurance

Insurance Company: ______________________________

Contract #: ______________________________

Group #: ______________________________

Policy Holder: ______________________________

Policy Holder DOB: ______________________________

Relationship to Child: ______________________________

BAMA PEDIATRICS
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Bama Pediatrics Payment Policy

Thank you for choosing us as your primary care provider and/or allergy specialist. We are committed to providing you with quality and affordable health care. Please read it carefully, ask us any questions you have and sign in the space provided.

1. **Insurance**: We participate in most insurance plans, including BCBS, Medicare, Medicaid, UHC, Aetna, Cigna, etc. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are uninsured by a plan we participate in but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. It is your responsibility to know your insurance benefits. Please contact your insurance company if you are not sure of your coverage. We file your insurance as a courtesy and we cannot make them pay.
2. **Co-payment and Deductibles**: All co-payments and deductibles must be paid at the time of service. The arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services**: Please be aware that some and perhaps all of the services you received may be non-covered or not considered reasonable or necessary by some insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance**: All patients must complete our patient information form before seeing a doctor. We must obtain a copy of your current valid insurance card to obtain proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If your insurance changes, it is your responsibility to notify our office. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
5. **Claims Submission**: We will submit your claims and assist you in any way we can to get your claims paid within reason. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
6. **Nonpayment**: Our billing company will send out two (2) statements and a priority letter before turning your account over to collection. You will be required to pay your balance at your next appointment. Nonpayment may result in you or your child not being seen at our office and possible dismissal from our practice. If dismissal occurs, we will notify you through mail and you have 30 day to find a new doctor. During that 30 day period, our physician will treat you or your child.
7. **Missed appointments**: Our policy is to charge a fee of $25 for missed appointments. We reserve this time for you and your child. Excessive no shows and you may be asked to find another doctor. All fees will have to be paid at your next visit.
8. **Medical Records Fee**: If you or your child changes doctors please be aware there is a $20 fee per child. If there is a balance on your account that will have to be paid in full. It does not matter if you or another doctor's office requests them. The fee is the same. Please beware there is a 72 hour notice for all medical records. Please note Alabama Law allows us to charge a $5 fee for a medical records search and $ .50 for the first 25 pages and $ .25 for any additional pages.
9. **Immunization Records**: We require a 48 hour notice for a Blue Card request. If you owe a balance, it has to be paid in full before the Blue Card will be release to you.
10. **After-hours calls**: Due to the high volume of non-urgent call we are now charging $10 for any calls that are not urgent made to our after-hours call center.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. **Please let us know before you sign this agreement if you have any questions or concerns.**

I have read and understand the payment policy and agree to abide by its guidelines.

_______________________________________ ________________________
Signature of patient or responsible party Date

____
Print name of responsible party

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Safeguarding the protect healthcare information (PHI) of our patients has always been and will always remain a primary concern of entire staff at BAMA PEDIATRICS LLC, Sudha Sagar Bennuri, MD and Bindu Bennuri, MD. Disclosure documentation and written consent to PHI as well as “chains of trust” with our vendors, appropriately executed contracts with business associates and “minimum necessary” release of information standards will provide a front line determent to any breach of practice procedures.

Moreover, through staff and provider training with periodic updates and monitoring Bama Pediatrics engineered office policy and procedure standards will protect orally (spoken) thereby ensure compliance with Federally mandated act known as Health Insurance Portability and Accountability Act of 1996 (HIPPA).

My affixed signature to this document acknowledges my awareness of the established practice and policy of Bama Pediatrics to protect the PHI of all patients under its care.

I, ____, acknowledge that I have received a copy of privacy practices at Bama Pediatrics, LLC, Sudha Bennuri, MD and Bindu Bennuri, MD.

Name of the Patient: _____________________________________

____
Signature of patient/patient’s guardian/ representative

____
Name of the person signed

Date: ______________________

BAMA PEDIATRICS
920 Rose Drive
Northport, AL 35476

Patient's Name: ________________________________

DOB: ____

Please list all names below that are allowed to accompany your child(ren) to Bama Pediatrics.

- By writing these names, you are allowing them to sign the consent for Authorizations for Payment and Treatment.
- Please be advised that patient's health information may be shared with whomever is accompanying the child(ren).

NAME:	RELATIONSHIP:
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________
_______________________________________	________________________________

I, _______________________________, give the above listed person(s) permission to make informed decision in the care of your child (such as immunizations, allergy shots, allergy testing and any medical necessity decision and/or procedures).

_______________________________________ ____
Print Legal Name Signature

____
Date

Bama Pediatrics
920 Rose Drive
Northport, AL 35476
Phone (205) 333-5900
Fax (205) 333-6090
Direct message: bama.peds@al1050.direct.successehs.com

____ ____
Patient's name Date of birth

I authorize _________________________________ to use or release/disclose my health information as described below.
Please identify the information to be released:

- ☐ Please release my entire records
  -OR-
- ☐ Please release only the following information
  - ☐ Immunization records ☐ X-ray and imaging reports ☐ Lab results
  - ☐ List of allergies ☐ Consultation reports ☐ Other __________________

The identified information will be used for the following purposed:

- ☐ My personal records
- ☐ Transferring to another doctor
- ☐ Other (please describe):____

Please initial each item below to indicate your understanding:

______I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

______ I understand once the information below is release, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

______I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure heath care treatment.

Reason for leaving the practice:____.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _________________________________ Phone: ___________________________________
Address: _________________________________ Fax: ______________________________
____

This authorization will expire on ____________________.
If I fail to specify an expiration date or event, this authorization will expire in twelve (12) months from the date on which it was signed.

____ ____________________________________
Print name of person signing release Relationship to patient

____ Date: _______________________________
Signature (or signature of person completing for if not patient)

____ __________________________________
Signature of Witness Date