Shoreline Pediatrics
Authorization to Share Information with Caregivers

Patient's Name_____ Date of Birth _____

I authorize the release and/or sharing of information about the persons named above to be released to the following individuals or entities:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

These individuals have an active and pertinent interest and role in my children's lives and may need information at any time. Information may be shared with them by phone, mail, and fax or may be left on an answering machine.

This authorization will remain in effect until I revoke it in writing.

Print Name of Person Authorizing Release	Relationship
Signature of Person Authorizing Release	Date

PLEASE COMPLETE BOTH SIDES.PLEASE COMPLETE BOTH SIDES

Account _____ Provider: _____

Date: _____ How did you hear about our office?_____

Please fill in all information completely. This information will help us better serve you and help assure that the billing process is accurate.

Patient: Name: Last _____ First _____ Middle _____
Social Security # _____ Sex _____ Birthdate _____
Address _____ Telephone_____
City _____ County _____ State _____ Zip _____

With whom does the patient live? _____Relationship _____

Father: Last _____First _____ Middle _____
Social Security # _____Sex _____ Birthdate _____
Address _____ Telephone _____
City _____State _____ Zip _____
Employer _____ Telephone _____

Mother: Last _____First _____ Middle _____
Social Security # _____Sex: _____ Birthdate: _____
Address: _____Telephone _____
City: _____State: _____ Zip: _____
Employer: _____Telephone _____

Parental Status: Married ____ Divorced _____ Single _____ Widowed ____

Stepfather: Last _____First _____Middle _____
Social Security # _____ Birthdate _____
Address: _____Telephone _____
City _____State: _____ Zip: _____
Employer _____ Telephone _____

Stepmother: Last _____First _____Middle _____
Social Security # _____Birthdate: _____
Address: _____Telephone _____
City: _____State: _____ Zip _____
Employer: _____Telephone _____

Other: Relationship to Patient:_____
Last _____First _____Middle _____
Social Security # _____ Birthdate _____
Address: _____Telephone _____
City: _____State: _____Zip: _____
Employer: _____Telephone: _____

'LEASE COMPLETE BOTH SIDES.PLEASE COMPLETE BOTH SIDES

Patient Name _____ Birthdate _____

Who has court-ordered physical custody of the child?
Mother _____ Father _____ Both _____ Foster _____ Other _____
Who is required by court order to provide the insurance for this child?
Mother _____ Father _____ Both _____ Foster _____ Other _____

We must have information for ALL plans, <u>including copies of all ID cards, divorce decrees, and court orders.</u>

Siblings who visit our practice: **FULL NAMES PLEASE**

Last _____ First _____ Birthdate _____ Sex ____

Last: _____ First _____ Birthdate: _____ Sex ____

Last: _____ First _____ Birthdate _____ Sex ____

Last: _____ First _____ Birthdate _____Sex ____

Last: _____First _____ Birthdate: _____Sex ____

FOR ALL PARENTS/GUARDIANS

Please sign below stating that you have reviewed this information and that it is now correct:

Parent/Guardian Signature:	Date	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you.

PARENTAL CONSENT FOR CARE IN ABSENCE OF PARENT

I, _____ give permission for the following persons 18 years of age or older to bring my child, _____ to Shoreline Pediatrics for **sick visits only** when I am unable to attend the scheduled appointment time. This consent is valid until I revoke it in writing.

Name	Telephone	Relationship to Child
Name	Telephone	Relationship to Child
Name	Telephone	Relationship to Child

Signature of Parent or Legal Guardian _____ Date _____

I, _____ give my permission for the following person who is 18
(Print Your Name)
years of age or older and who is a primary care giver for my child to bring
_____ to Shoreline Pediatrics for **well child care**. I understand
(Print Child's Full Name)
that only a parent or legal guardian may consent to immunizations and/or testing. I agree to come in to the office on the day of the scheduled appointment *prior* to the time of the appointment to receive vaccine information sheets and sign vaccination records as needed. This consent is valid until I revoke it in writing.

Name	Telephone	Relationship to Child
Name	Telephone	Relationship to Child
Name	Telephone	Relationship to Child

Signature of Parent or Legal Guardian _____ Date _____

ACKNOWLEDGMENT OF NOTICE

You are hereby notified pursuant to Michigan Law that as a patient of this practice your child may be tested for the presence of HIV or an HIV antibody without your consent if any health professional or other health facility employee sustains a percutaneous membrane open wound exposure to your child's blood or other body fluids. This test is permitted by Michigan Law and is for the protection of your child as well as the protection of the physicians and employees of Shoreline Pediatrics, P.C.

_____

Child's Full Name (please print)

_____ _____ _____

Signature of Parent/Legal Guardian Date Witness

Shoreline Pediatrics, PLC

Patient Name _____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

1. **Patient With Insurance**
You are responsible for deductibles, copays, noncovered services, coinsurances and items considered "not medically necessary" by your insurance company. Copays and coinsurance amounts are due at the time services are rendered. The remaining balance should be taken care of within one (1) month of the notice from your insurance company. If you or your insurance carrier makes payments exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify us in advance to make arrangements. **It is your responsibility to know what your insurance covers/pays.**

2. **Personal Injury (Accident)**
If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing.

Assignment

I assign the benefits from my insurance carrier(s) to Shoreline Pediatrics, PLC for medical/surgical benefits I am entitled to.

Release of Information

I authorize Shoreline Pediatrics, PLC to release to my insurance carrier(s) and/or CMH (Medicaid) and its agents any information needed to determine benefits payable for related services.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me.

X_____

Parent or responsible party signature Date

_____

Person signing on behalf of patient (Print Name) Relationship to Patient

_____

Address Phone

Shoreline Pediatrics, PLC

Name of Patient _____ Date of Birth_____

I understand and agree to accept responsibility for payment of services if my insurance plan denies payment for services because:

- My Primary Care Provider (PCP) has not authorized the services (if PCP is other than a provider within Shoreline Pediatrics).
- I fail to enroll my child within my insurance plan's allowed enrollment period; or I fail to select a provider within Shoreline Pediatrics as my child's Primary Care Provider.
- I retroactively change my Primary Care Provider to a provider in another practice after services have been provided.
- I fail to supply Shoreline Pediatrics with adequate information to submit claims to my child's insurance carrier (I.e. SSN's, addresses, etc.)
- I fail to respond to requests for additional information by my child's insurance plan.
- I fail to provide a copy of a court order or divorce decree, including pages outlining responsibility for health insurance and medical care as well as pages containing names and signatures.
- I am responsible for paying for services and submitting the claim to my insurance plan if Shoreline Pediatrics does not participate with my insurance plan.

It is your responsibility to know what your insurance plan covers. It is also your responsibility to keep our office informed of all insurances that cover your child as well as any changes in coverage or plans.

We do not get involved in disputes between parents of our patients over the payment of services provided by us. It is our policy that the parent or guardian seeking medical service is responsible for payment of those services at the time they are rendered. Monthly statements are sent to the parent listed as the guarantor in our records.

If you are experiencing financial hardship or difficulty meeting obligations, please discuss it with our billing department. If you have made arrangements to make payments on a past due bill, you must adhere to the agreement.

If you have any questions, we will be happy to discuss them with you.

_____ _____

(Parent Signature) (Date)