CHALLIE A. MINTON, MD PC / SURRY RURAL HEALTH CENTER

Financial Policy

The Financial Policy is to help us provide the most efficient and reasonable health care services to all patients. Therefore, it is necessary for us to have a Financial Policy stating our requirements for payment for services provided to patients. **Patients are responsible for the payment of all services provided.**

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at checkout.

Insurance Policy

If you are an insurance patient, it is our policy to file to your insurance as a courtesy to you. It is your responsibility to make sure we have accurate and complete insurance information so your claim can be filed in a timely manner.

- If we do not have the correct information, you will be the responsible party for the services. Payment for services will be collected at the time of your visit.
- If you pay for services at the time of your visit or are billed for services for your visit due to not providing accurate insurance information, we will not re-file a past claim. You will be responsible for filing the claim for reimbursement from the correct insurance company if you wish to do so.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- You will be the responsible party for deductibles, co-payments, coinsurance, and out-of-network costs.
- You will be the responsible party for out of network services.

Workers Compensation Policy

- If you are a worker's compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments from the worker's compensation carrier.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within thirty (30) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

24 Hour Cancelation & "No Show" Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Challie Minton MD PC reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") that are not canceled with a 24-hour notice. "No show" fees will be billed to the patient. This fee is not covered by your health insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Overdue and Credit Balances Policy

- Over-due balances are to be paid with the agreed amount before you may schedule appointments.
- Over-due patient balances will be sent to collections.

To help with these policies, we ask that you assist us by:

- Providing us with current and updated information on yourself, your insurance company, and understanding your insurance policy. Please familiarize yourself with your co-pay, deductible, and coinsurance amounts.
- Presenting an updated insurance card.
- Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a self-pay patient.
- To provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the providers or clinical staff. Please discuss any account information with the front office manager, front staff, or practice administrator.

By signing below, I am stating that I have received, read, and agree to the Financial Policy.

Signature:

Printed name:

Relationship to patient:

Child Demographic Form

Child Demographics		
First Name	**Middle Initial**	**Last**
Date of Birth	**Sex ☐Male ☐Female**	**Social Security #**
Race	**Ethnicity**	**Preferred Language**
Address		
City	**State**	**Zip**
Who does the child live with primarily? ☐Mother ☐Father ☐Other **If other, indicate relationship:**		

Mother's Information		
Frist Name	**Middle Initial**	**Last**
Home Phone	**Cell Phone**	**Social Security #**
Address		
City	**State**	**Zip**

Father's Information		
Frist Name	**Middle Initial**	**Last**
Home Phone	**Cell Phone**	**Social Security #**
Address		
City	**State**	**Zip**

Legal Guardian Information (If the legal guardian is not a parent)		
Frist Name	**Middle Initial**	**Last**
Home Phone	**Cell Phone**	**Social Security #**
Address		
City	**State**	**Zip**

Authorization to Release Information and Benefits: I hereby authorize Challie Minton M.D. to release any medical information to the insurance company(s) that I designate and to the agents to determine benefits of benefit related services rendered.

Acknowledgement of Notice of Privacy Practices: I acknowledge that I have received a copy of Challie Minton M.D. Notice of Privacy Practices.

Consent to treatment: I authorize Challie Minton M.D. to treat my child as a patient. I authorize Challie Minton M.D. to send forms, shot records or discuss general medical information with my child's school, daycare, or headstart.

By signing below, I am stating that I have received, read, and agree to the policies above.
Signature:
Printed name:
Relationship to patient:

Consent to Treat Minor Child Without Parent/Guardian Present

As the parent or legal guardian of the minor child listed on this form, I authorize for the adults listed below to accompany my child to their visit in my absence. I authorize these adults to consent to treatment for my child on my behalf. Treatment may include but is not limited to diagnostic testing, blood draws, shots, x-rays, ultrasounds, and administration of medications. I understand that the people listed must be legal adults that are capable of making informed decisions. I am aware that the adult accompanying my child at their appointment may be responsible for payment of any copays, coinsurance, or other services rendered at the time of my child's visit. My consent will remain effective until the named minor reaches the age of 18 or I revoke with authorization myself in writing.

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

☐**Treatment may NOT be provided to the minor child without the presence of a parent or legal guardian (with the exception of certain medical care specified by state and federal laws).**

Parent/Guardian Signature:	**Date:**

Consent to Treat Minor Over 16 Years Old Without an Accompanying Adult

I authorize the employees of Challie A Minton MD PC to treat the above-mentioned minor without a parent, legal parent, or authorized adult present during the office visit. Treatment includes but is not limited to diagnostic testing, blood draws, shots, x-rays, ultrasounds, and administration of medications. I understand that I should be able to be reached by phone during my child's visit if something is needed. I understand that my child may be responsible for paying any copays, coinsurance, or other services rendered at the time of the visit. My consent will remain effective until the named minor reaches the age of 18 or I revoke with authorization myself in writing.

☐**Treatment may NOT be provided to the minor child without the presence of a parent or legal guardian (with the exception of certain medical care specified by state and federal laws).**

Parent/Guardian Signature	**Date**

HIPAA Compliance Patient Consent and Medical Information Release Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that: *Protected health information may be disclosed or used for treatment, payment, or healthcare operations. *The practice reserves the right to change the privacy policy as allowed by law. *The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. *The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. *The practice may condition receipt of treatment upon execution of this consent.

Parent/Guardian Signature	**Date**

Patient Medical History Form

Name_____ **Date of Birth**_____

Complete the form the best you can. If you need additional space for any section, please let a staff member know.

Preferred pharmacy:

List any of your current medications with dosages:

List any known allergies you have:

List any diseases that your family members have been diagnosed with:
***Example: Diabetes, High Blood Pressure, Cancer, Lung diseases, Strokes**

Family Member	Disease(s)

List any surgeries your child has undergone with dates:

Check any of the following problems that apply to you

❑Headaches	❑Trouble with vision	❑Trouble with hearing
❑Allergies / hay fever / asthma	❑Thyroid issues	❑Diabetes
❑Skin problems	❑Anemia / abdominal bleeding	❑Heart problems
❑Circulation problems	❑Fainting	❑Chest pain
❑Lung problems	❑Coughing / wheezing	❑Liver disease / jaundice
❑Gallbladder issues	❑Stomach problems	❑Change in bowels
❑Abdominal pain	❑Kidney disease / stones	❑Urinary problems
❑Female / male issues	❑Weight loss / gain	❑Depression
❑Anxiety	❑Psychiatric issues	❑Other

If other, please specify:

Please list any other information you feel is important regarding your child's health