****This form is for your personal use only and is a tool to help you understand your personal health benefits****
Call your insurance company (phone number on the back of your insurance card) and ask them to send you a summary of benefits for your (or your child's) current plan.

Insurance company name: _____

Customer Service #: _____

Policy ID #: _____ **Group #:** _____

Effective Date: _____ **Renewal Period:** _____

Policy holder name: _____ **Policy holder date of birth:** _____

Do I have to choose a Primary Care Physician? Yes No

If yes, is that the physician listed on my card? Yes No
If it is not, call your insurance company and have them change the Children's Medical Center to one of Children's Medical Center physicians.

Individuals covered under this plan: _____

_____

Deductible Amount: $_____**/Individual &** $_____ **/Family**

Out of pocket max: $_____**/Individual &** $_____ **/Family**

General Office Visit:	Copay $_____	Co-Insurance $_____	Deductible $_____
Specialist visit:	Copay $_____	Co-Insurance $_____	Deductible $_____
Hospital:	Copay $_____	Co-Insurance $_____	Deductible $_____
Prescription*:	Copay $_____	Co-Insurance $_____	Deductible $_____
Radiology:	Copay $_____	Co-Insurance $_____	Deductible $_____

**Prescription benefits may have different levels of coverage (tiered)*

Questions to ask your insurance company specifically how they process wellness visit charges:

1. How many wellness visits can my child have between the age of newborn and 4?_____
2. At what age is my child limited to one wellness visit per year? _____
3. Is that per calendar year or from last wellness visit?_____
4. How does my plan pay for routine immunizations?_____
5. Do I have co-insurance or a deductible to meet for immunizations?_____
6. Is there a wellness maximum amount that my insurance company will pay?_____
7. If so, what is that amount? _____
8. Who is my preferred lab?_____

703 Verdae Blvd.
Greenville, SC 29607
Tel: 864.288.5402
Fax: 864.234.7961

3455 Highway 153
Piedmont, SC 29673
Tel: 864.295.8811
Fax: 864.295.0806

307 North Main St.
Simpsonville, SC 29681
Tel: 864.228.8010
Fax: 864.228.8050

841 South Buncombe Rd.
Greer, SC 29650
Tel: 864.877.1220
Fax: 864.877.7731

First: _____ Middle: _____ Last: _____ Sex: ___ DOB: ___/___/___ SS#: ____-____- _____

First: _____ Middle: _____ Last: _____ Sex: ___ DOB: ___/___/___ SS#: ____-____- _____

First: _____ Middle: _____ Last: _____ Sex: ___ DOB: ___/___/___ SS#: ____-____- _____

First: _____ Middle: _____ Last: _____ Sex: ___ DOB: ___/___/___ SS#: ____-____- _____

How did you hear about our practice?

☐ Facebook ☐ Friend/Family ☐ Web ☐ Other

Patient Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Email:** _____

Mother: _____ **Father:** _____

SS#: _____ **SS#:** _____

Cell: _____ **Cell:** _____

DOB: _____ **DOB:** _____

Other than Parent:

Emergency Contact Name: _____ **Emergency Contact Number:** _____

Address: _____ **Relationship to Patient:** _____

In the event of an emergency situation and the clinic is unable to reach the above legal guardians I or we Grant my or our permission for emergency care, treatment, transportation, hospitalization or any other physicians to be called in connection with the care needed for the above listed child(ren).

Signature of Guardian: _____

Pharmacy Name: _____

Pharmacy Number: _____

Pharmacy Address: _____

Person Responsible For The Bill Is The Person Who Brings In The Child

Name of Person Responsible: _____

DOB: _____ **SS#:** _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Insurance Information

Primary Insurance: _____

Effective Coverage Date: _____

Group #: _____ **Policy/Subscriber #:** _____

Insurance Address: _____ **City/State/Zip:** _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ **SS#:** _____

Employer: _____ **Phone #:** _____

Home Address (if different from above): _____

City/State/Zip: _____

** I authorize the release of any medical information necessary to process claims **

Signature: _____ **Date:** _____

** I authorize payment of medical benefits to services described above **

Signature: _____ **Date:** _____

Consent Form

Patient Name: _____

DOB: _____ **SS#:** _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

In accordance with HIPAA regulations, we require consent to provide treatment, release account information and discuss any healthcare operations in your absence. Listed below are the people I give permission for your office to speak with and receive information requested. Please **CHECK** the information below that you authorize Children's Medical Center to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

- ☐ Results of lab test/x-rays
- ☐ Appointment Information
- ☐ Billing Information
- ☐ Medical Information

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

The people listed below DO NOT have the permission to receive any information regarding my child's healthcare or any account information. (If a parent is listed to not receive any information regarding your child's health or any other information we require court documentation on file to honor this request.)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

Financial Policy

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

Payment for Service: We require that you pay your deductible, co-payment, and/or any charges not covered by insurance. As a courtesy to you, we will file your insurance if you provide us with a copy of your current insurance card.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $35.00 service charge will be added on all checks returned to us for insufficient funds.

Forms Fee: There will be a $15.00 fee charged for all forms (sports, physical, camp, etc.) to be completed when not needing a scheduled office visit.

Copies of Medical Records: There may be a charge for completion of this service (SC Sec. 44-7-325 for Health Care Facilities):

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $25.00
- Plus actual postage

No Show Appointments: A fee of $25.00 may be charged for missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify your home office of any cancellations during normal office hours.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. If you are unable to pay your balance promptly, please call the billing office at 864-752-0510 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded to a collection agency.

Signatures: I have read and understand these financial policies:

Guarantor Signature: _____

In my absence, the following people have permission to bring my child for medical care at Children's Medical Center, P.A.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I consent to my child receiving regularly scheduled immunizations at Children's Medical Center, P.A.

Signature: _____ **Date:** _____

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