Abilene Children's Medical Association, LLP

2150 Cedar St. Abilene, Texas 79601 | 414 Lone Star Dr Ste A, Abilene, Texas 79602

Patient Information

Name (Last)_____ (First)_____ (MI)_____

Date of Birth_____ Age_____ Sex □ M □ F

Address (Street)_____

(City,State,ZIP)_____

Relationship to Guarantor_____

Phone #_____ Guardian Email Address_____

At which hospital was this child born?_____

Mothers Full Name_____ Mothers Social Security #_____

Mothers Date of Birth_____ Mothers Maiden Name_____

Fathers Full Name_____ Fathers Date of Birth_____ Fathers Social Security #_____

Other children seen at this office_____

Which is your preferred pharmacy? _____

Responsible Party/Guardian Information

Name (Last)_____ (First)_____ (MI)_____

Address(Street)_____(City,State,ZIP)_____

Employed? Y / N Place of Employment_____

Home Phone#_____ Cell Phone #_____Work Phone #_____

Date of Birth _____ Social Security # _____ Marital Status _____

Emergency Contact / Person(s) authorized to bring child to appointments

Name	Relationship to Patient	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insurance/Medicaid Information

Policy Holder_____

Relationship to Patient_____

Social Security#_____

Date of Birth_____

Insurance Name_____

Policy#_____

Group #_____

Policy Holder_____

Relationship to Patient_____

Social Security#_____

Date of Birth_____

Insurance Name_____

Policy#_____

Group #_____

I have reviewed and understand the office policies of Abilene Children's Medical Association.

I hereby assign, transfer, and set over to Abilene Children's Medical Association, LLP all of my rights, title and interest to my medical reimbursement benefits under my Private Insurance or Medicaid policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by Private Insurance or Medicaid.

Responsible Party Signature_____Date_____

Abilene Children's Medical Association

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient Representative Relationship Date

_____

Name of Patient(s)

By my initials, I authorize ACMA to contact me by the designated means noted below and to leave messages regarding appointments, medical results and billing issues:

_____ Home Phone _____ Cell Phone and Voice Mail

_____ Home Answering Machine/Voice Mail _____ Office/Work Place Phone and Voicemail

Signature: _____ Date: _____ Effective until: _____

If not indicated, one year from date signed

I authorize ACMA to disclose private health information to the following schools/daycare programs for the purpose of continuity of care:

Childs Name	DOB	School/Day Care	Authorization Effective until (date) If no date is specified, authorization valid for one year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature:_____ Date:_____

Abilene Children's Medical Association, LLP

2150 Cedar St.
Abilene, TX 79601
(325) 677-6067

Paige LeMasters, M.D., F.A.A.P.
Kelly Palmere, M.D., F.A.A.P.

414-A Lone Star Dr.
Abilene, TX 79602
(325) 793-9973

Tushar M. Shah, M.D., F.A.A.P.
Rachel Anderson, M.D., F.A.A.P.

Understanding Your Visit and Insurance Billing

SICK VISIT This is an office visit for an acute problem or flare-up of a chronic problem. This could also be an office visit to follow-up on chronic problems (headaches, allergies, asthma, etc.).

WELL VISIT This is an office visit for a routine physical exam and to assess and monitor your child's overall health and development.

SICK/WELL VISIT This is a combination visit of a well visit exam where an acute or chronic issue is also addressed. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a combination visit and must be billed differently than just a well visit or just a sick visit.

WHY IT IS BILLED DIFFERENTLY It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, x-ray, referrals and/or prescription medications). It involves additional documentation as well. **Physicians are required to document any and all issues addressed and include that documentation when filing claims with your insurance company.**

HOW THIS AFFECTS ME Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to pay a copay for these visits, even if your insurance does not require a copay for well visits alone.

Well visits target preventive care and are billed as such**. Medication refills and/or other ailments, injuries, or illnesses addressed during a well visit are billed IN ADDITION to the annual physical.** These charges may be determined by your insurance to be the patient's responsibility. Also, some in office procedures may be applied to your deductible, according to your specific coverage. Please contact your insurance company to confirm your coverage for all types of doctor visits.

We realize this can be confusing, and if you have any questions or concerns after reviewing this material, please ask or contact our billing office at 670-5705.

Patient(s) Name and DOB

Responsible Party Name and Signature **Date**

Please let us know if you would like a copy for your records