Revised 5/2020

40920 US HWY 280
Sylacauga, AL 35150
Phone: 256-208-0060
Fax: 256-208-0755

398 Chesser Dr. Suite 7
Chelsea, AL 35043
Phone: 205-678-1286
Fax: 205-618-9696

Patient Information:

Child's Name: Last_____First:_____Middle:_____

Child's Birthday:_____Child's Social Security Number: _____

Child's Sex:_____Child's Race:_____ Ethnicity:_____Patient lives with:_____

Address: _____

City:_____State:_____Zip: _____

How would you like to be reminded of your child's appointment? **Please Rate your method 1, 2, & 3**_____Text_____Phone Calls_____E-Mail

Parent/Guardian:_____	Parent/Guardian:_____
Birthdate:_____ SS#:_____	Birthdate:_____SS#:_____
Address: ☐ Check if same as patient address	Address: ☐ Check if same as patient address
_____	_____
Phone (H) _____	Phone (H) _____
Phone (C) _____	Phone (C) _____
Phone (W) _____	Phone (W) _____
Email _____	Email_____
Circle your relation to the patient: Genetic? Y☐ N☐	Circle your relation to the patient: Genetic? Y☐ N☐
Mother/Father Step-parent Foster Parent Guardian	Mother/Father Step-parent Foster Parent Guardian

Siblings: Last Name, First Name Gender Date of Birth

_____	F M	_____
_____	F M	_____
_____	F M	_____
_____	F M	_____

Consent For Treatment: I consent to necessary treatment, including drugs, medicine, performance of operation and conduct x-ray, or other studies that may be used by the attending physician, nurse or staff.

Authorization For Release Of Information: I authorize Pathway Pediatrics to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. I consent for Pathway Pediatrics to import my medication history from my insurance company/pharmacy.

Assignment of Benefits: I hereby authorized payment directly to Pathway Pediatrics of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Pathway Pediatrics charges for the services. I understand that I am financially responsible to Pathway Pediatrics for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage are subject to coordination of benefits.

Guarantee of Account: For services furnished by Pathway Pediatrics I hereby guarantee the payment of all accounts for services rendered**. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney's fee and a collection fee of 50% of the balance due.**

Signature:_____Date: _____

Communication Authorization Form

Patient Name:_____DOB: _____

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other persons with whom we can discuss you/your child's care and share protected health information to.

Please list below any people with whom you authorize our office to discuss aspects related to your child's care.

Name:_____Phone number:_____Relationship to patient: _____

Name:_____Phone number:_____Relationship to patient: _____

Name:_____Phone number:_____Relationship to patient: _____

Name:_____Phone number:_____Relationship to patient: _____

I have received a copy of the Privacy Practices from Pathway Pediatrics: Yes _____ No_____ Declined copy_____

Patient Signature:_____Date: _____

Electronic Prescription Form

I,_____, whose signature appears below, authorize Pathway Pediatrics, Inc. Providers to view the external prescription history via the RxHub service for the patient listed below.

By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

_____
(Patient Name)

Preferred Pharmacy:_____Location: _____

My signature certifies that I read and understand the above and that I authorize the access.

_____ _____
(Signature of Patient/Guardian) (Date)

_____
(Guardian's Relationship to patient)

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Insurance Information

Person responsible for account:_____D.O.B _____

Card Holder's Social Security Number:_____Relationship:_____

PRIMARY Insurance Company: _____

Policy/Contract ID number: _____

Policy holder's name: _____

Person responsible for account:_____D.O.B _____

Card Holder's Social Security Number:_____Relationship:_____

SECONDARY Insurance Company: _____

Policy/Contract ID number: _____

Policy holder's name: _____

Easy Pay Agreement

This service will allow you to pay co-pays, deductibles, and patient balances left by your insurance company easily and conveniently.

With this service you authorize Pathway Pediatrics, Inc to use this credit card as the form of payment for balances accrued, including lab test, co-pays, coinsurances, and deductibles. This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. We will obtain verbal consent prior to payment processing. **This agreement will expire on the expiration date listed below**. The card holder may revoke this consent at any time in writing.

Visa ☐ **MasterCard** ☐ **Discover** ☐

Credit Card Holder's Name: _____ DOB: ___/___/____
(Please Print)

Last Four Digits of Account Number: _____

Expiration Date: _____

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: _____ DOB: ___/___/____
(Please Print)

Patient Full Name: _____ DOB: ___/___/____

Patient Full Name: _____ DOB: ___/___/____

Credit Card Holder's Signature:_____Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Address: _____

Phone Number:_____ Date of Birth: _____

This Authorization applies to the following information:

☐ All Information/ Complete Medical Records.
I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information. This authorization will expire in 90 days.

☐ Only the follow records or types of Information: _____

Treatment Dates: From (___/___/___) to (___/___/___)

The Information may be release as follows:

☐ From Pathway Pediatrics, Inc.
40920 US HWY 280
Sylacauga, AL 35150

☐ To: _____
_____
_____

Or _____

☐ From: _____
_____
_____

☐ To: Pathway Pediatrics, Inc.
398 Chesser Dr, Suite 7
Chelsea, AL 35043
Fax: 205-618-9696

☐ To: Pathway Pediatrics, Inc
40920 US HWY 280
Sylacauga, AL 35150
Fax: 256-208-0755

Purpose of the release

☐ Continuity of Treatment ☐ Other (Please Specify): _____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subjected to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical records copies, please ask about the coy fee by law that may apply. I represent that I have the authority to voluntary grant permission for the information to be released as described above.

_____ _____
(Patient/Parent/Legal Guardian Printed Name) (Patient/Parent/Legal Guardian Signature) Date

_____ _____
(Witness Signature for Patient/Parent/ Legal Guardian) Date