



## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Madison-Ridgeland Children's Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Madison-Ridgeland Children's Clinic for services rendered in my medical care. If the assignment is accepted, I understand that I am financially responsible for any balances not covered by my insurance. **Co-pays are due at time of service.**

A photocopy of these assignments shall be valid as the original.

\_\_\_\_\_  
Patient (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian (please print)

\_\_\_\_\_  
Signature

## CONSENT TO TREAT

I, \_\_\_\_\_, do give Dr. Leslie L. Jones / Dr. Leslie B. Delaney / Dr. William D. Payne / Dr. James H. Stewart / Dr. Ashley W. McGlawn and their staff my permission to administer medical treatment to

\_\_\_\_\_  
(Name of Patient)

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
(Relationship to patient)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

MADISON - RIDGELAND  
CHILDREN'S CLINIC

LESLIE DELANEY, M.D.  
LESLIE L. JONES, M.D.

401 BAPTIST DRIVE, SUITE 101  
MADISON, MISSISSIPPI 39110  
(601) 856-2598 • Fax: (601) 856-4459

WILLIAM D. PAYNE, M.D.  
JAMES H. STEWART, M.D.  
ASHLEY WINFORD, M.D.

Madison-Ridgeland Children's Clinic Payment Policy

We try to provide you with the highest quality medical care available. We also realize that medical costs are of concern to you. Our staff works very hard to keep down expenses by keeping down costs. We've developed the following guidelines to help.

We are contracted with the following insurance companies: Blue Cross & Blue Shield (Federal, Regular, and State) MS Health Partners, MS Physician Care Network, United Healthcare, United Healthcare Chips, First Health, Tricare (Prime and Standard), and Aetna. We will file your claims for you. You will be expected to pay your copay at the time of service. All insured patients will be expected to pay the network charges per our contract rates with the insurance company. For all other insurance companies with which we are not contracted, you will be expected to pay for all charges at the time of service with the exception of hospital charges. We accept cash, check, Visa, MasterCard, American Express, and Discover. You will be provided a claim form to file for reimbursement to you. Please note that your insurance is a contract between you and your carrier, and very few insurance companies cover all medical expenses. It is your responsibility to know your policy benefits.

Returned Checks- Checks that are returned due to non-sufficient funds will be required to pay the amount in full along with a \$40.00 service charge. We realize that sometimes this may be an oversight and if you are aware, please contact our office to assist us in arrangements for payment. We will accept only cash, money order, or certified check at this point. Unless this amount is paid within the time specified, MRCC may turn over the check to the proper authorities for collection. If this happens, the patient will be held responsible for any and all court costs.

Minor Patients- In special situations, such as divorced parents, whichever parent brings the child in for treatment is the one responsible for the bill.

Failure to make payment in full or on a scheduled payment date will be considered default and could cause referral for additional collection efforts. Depending on the circumstances, we may use a third party collection agency or litigation or both.

*I hereby understand the payment policy of MRCC and agree to the above policy. I hereby agree to be responsible for payment of my account. If not paid when due, I will be responsible for all collection fees, interest accrued, and/or attorney fees. I do understand that if MRCC does not have a contract with my insurance company I am responsible for all charges, and I will be expected to pay in full for services rendered.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

*I hereby authorize MRCC and their doctors to release any information regarding services rendered by him/her or the corporation employees and to allow a photocopy of my signature to be used to file insurance. I authorize and direct my insurer to issue payment for services rendered by the doctors to be made directly to MRCC or the doctor. Regardless of my insurance benefits, I understand and accept responsibility for any unpaid balances.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Madison-Ridgeland Children's Clinic**

**401 Baptist Drive, Suite 101**

**Madison, MS 39110**

**Phone (601) 856-2598 Fax (601) 856-4459**

**Authorization for Use or Disclosure of Protected Health Information**

I authorize my physician and/or administrative and clinical staff of the Madison-Ridgeland Children's Clinic to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health information will not be disclosed except in those situations described in the Notice of Privacy for Madison-Ridgeland Children's Clinic.

Name and relationship of the person you wish to allow access to your health information. For example: your parents, spouse, sibling, grandparents, neighbor, caretaker, or close friends:

Name (Including Parents)

Relationship to Patient

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization to use and disclose protected health information is being submitted by my request and shall be in force and effect until revoked by me in writing. I understand that I have the right to revoke this authorization at any time by sending written notification to Madison-Ridgeland Children's Clinic. I understand that information used or disclosed pursuant to this authorization may be disclosed by the Madison-Ridgeland Children's clinic and may no longer be protected by Federal or State law.

\_\_\_\_\_  
Signature of Parent, Guardian, or Representative

\_\_\_\_\_  
Date

Facility: Madison – Ridgeland Children's Clinic PA

Address: 401 Baptist Drive, Suite 101

Privacy Official: Kathy Peace

Telephone: 601-856-2598 Fax: 601-856-4459

### Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Facility named at the top of this page. I understand further that the Medical Facility and its business associates (including its billing company) may use or disclose my health information in communications with third parties who are involved in or indicate that they are responsible for payment for my healthcare services. I understand that such third parties might include persons who are policy holders of any policy of insurance covering me. I acknowledge that I am entitled to prevent these communications by objecting to them, and by signature below, indicate that I DO NOT OBJECT to such communications.

Name of Patient: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_

Relationship to patient (parent, guardian, etc) \_\_\_\_\_

#### OPTIONAL DESIGNATION OF PERSONS TO WHOM WE MAY DISCLOSE YOUR RECORDS IN YOUR ABSENCE:

1. \_\_\_\_\_
2. \_\_\_\_\_

(You may also call us or personally inform us at any time of persons to whom we may disclose your records.)

For Facility Use Only:

Signature of Facility Employee

Date