Madison Ridgeland Children's Clinic
401 Baptist Drive, Ste. 101
Madison, MS 39110
(601) 856-2598 • Fax: (601) 856-4459

DATE:_____ Patient Acct #:_____

PATIENT REGISTRATION

PATIENT'S NAME_____ PATIENT GOES BY_____

DATE OF BIRTH_____ SEX M / F RACE _____ PATIENT SSN_____

ADDRESS_____

E-MAIL _____

PREFERRED PHARMACY_____ REFERRED BY_____

MOTHER'S NAME:	FATHER'S NAME:
MOTHER'S EMPLOYER	FATHER'S EMPLOYER
WORK TEL. NO. * CELL TEL. NO.	WORK TEL. NO. * CELL TEL. NO.
MOTHER'S SOCIAL SEC NO.	FATHER'S SOCIAL SEC NO.
MOTHER'S DATE OF BIRTH	FATHER'S DATE OF BIRTH

EMERGENCY CONTACT (OTHER THAN IMMEDIATE FAMILY)

NAME:_____ TELEPHONE:_____

INSURANCE & BILLING INFO

MEDICAL COVERAGE EFFECTIVE DATE_____

(1) PRIMARY_____ GROUP# ID#_____

Address: _____ Insured's Name:_____

(2) SECONDARY_____ GROUP# ID#_____

Address:_____ Insured's Name:_____

**If you have more than one medical insurance, the primary is based on which insured's birthday comes first in the year.

CHILD'S SIBLING'S AGE SEX

_____

_____

_____

_____

_____

_____

_____

_____

Please List Child's:

Medicine Allergies_____

_____

Food Allergies_____

_____

Surgeries_____

_____

Hospitalizations_____

_____

Serious Illnesses_____

_____

Chronic Family Illnesses_____

_____

Current Medications_____

PLEASE COMPLETE BACK OF FORM

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 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)

Facility Signature:_____ Date:_____

MADISON - RIDGELAND CHILDREN'S CLINIC

LESLIE B. DELANEY, M.D.
LESLIE L. JONES, M.D.
WILLIAM D. PAYNE, M.D.

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

JAMES H. STEWART, M.D.
ASHLEY W. MCGLAWN, 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 Physician Care Network, United Healthcare, Cigna, 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 his 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 friend:

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, Ste 101 Madison, MS 39110 Privacy Official: Lorrie Kahl
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 name 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, indicated 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: _____