Valley Children's Clinic

2226 Haine Drive
Harlingen, Texas 78550
Phone: (956) 423-1283

PATIENT INFORMATION

Name: _____

Address: _____

_____

City,State: _____

Phone: _____

Phone: _____

Email: _____

How did you hear about our clinic? _____

Patient ID #: _____ **Sex:**

Date of Birth: _____

Social Security #: _____

Referring Physican: _____

EMERGENCY CONTACTS

_____ _____

PHARMACY _____

GUARANTOR; [ ] Father [ ] Mother [ ] Other _____

Name: _____ **Employer:** _____

Address: _____ **Phone:** _____

_____ **Social Security #:** _____

City,State, Zip: _____ **Date of Birth:** _____

Email: _____

MOTHER: ***FATHER:*** _____

Name: _____ **Name:** _____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

Date of Birth: _____ **Date of Birth:** _____

PRIMARY INSURANCE Policy Holder: [ ] Patient [ ] Mother [ ] Father [ ] Other _____

Company: _____

SECONDARY INSURANCE Policy Holder: [ ] Patient [ ] Mother [ ] Father [ ] Other _____

Company: _____

AUTHORIZATION

I authorize payment of all benefits, for services rendered, be paid to Valley Children's Clinic. I authorize the release of any medical information needed to process my child's medical claims.

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges subject to coverage. I understand if my insurance deems the procedure to be a non-covered or payable procedure or does not pay for services rendered within 45 days of being billed I will be financially responsible for the full amount charged regardless of insurance contractual agreements.

By signing this form, you consent to the use and/or disclosure of protected health information about treatment, payment, and health care operations. You may revoke or restrict this consent in writing, except to the extent that this entity has already taken action in reliance thereon. This consent supersedes any prior consent. I have been given and reviewed the HIPAA, HIE, and Medical History Policy. I authorize Valley Children's Clinic staff to leave a message at any of the above listed numbers regarding my child's appointments, referrals, results, etc.

_____ _____

Patient, Parent/Legal Guardian, or Power of Attorney Signature Date

_____ _____

Witness Date

Valley Children's Clinic, P.A.

2226 Haine Drive
Harlingen, Texas 78550

Here is some helpful information about Valley Children's Clinic, PA and staff you need to know.

The staff at Valley Children's Clinic is committed to helping parents raise healthy children. This includes regular well child examinations and guidance for parents as well as treatment of illnesses and accidents as they occur. The Graduate Physicians and Health Care Providers are extensively trained in delivery of health care to adults and children. They work directly with the Pediatrician and consult with them regarding you or your child's examination and treatment plans. Your child's visit will be scheduled with one of the members of our Health Care Delivery Team. We will ensure that your child will be scheduled with a pediatrician on regular intervals.

I have read the above statement and DO consent to my child being seen by any member of the Health Care Delivery Team.

POLICIES FOR VALLEY CHILDREN'S CLINIC, PA

1. Insurance co-payment, picture ID and insurance card are due at the time of check-in. Your insurance company requires us to verify this information every visit.
2. Private Pay patients are required to make payment in full at the time services are rendered.
3. Valley Children's Clinic will only accept checks from local banks. We do not accept any temporary checks or third-party checks. There will be a $30.00 fee on all returned checks.
4. There will be a charge for any copies made of the patient's medical record including immunization cards. Fees for copying of medical records will abide by the Federal Register. A retrieval or processing fee per patient will be charged to the requester. The fee for providing the first 20 pages is $25.00, for each page there after $0.50 per page, plus the cost of postage. A fee of $5.00 up to $15.00 will be charged for issuing a new Immunization record. Valley Children's Clinic will replace an immunization card at no charge to the patient with proof that the card was stolen or destroyed by fire. An additional $5.00 fee will be charged on any document requiring a notary signature with stamp. No exceptions will be made to the policy.
5. It is the patient's responsibility to call prior to running out of your medication. Medication refill request to a local pharmacy or written scripts must be called in at least one week in advance.
6. Please arrive 5 minutes prior to your scheduled appointment time for registration or you will be considered a walk-in patient.
7. Any account balance over 90 days will be sent to collections and the account will be automatically dropped to an inactive status.
8. If patient no show's / no call's more than 4 times in a 6-month period the patient will not be allowed to schedule any appointments in the future. The chart will then be reviewed for possible termination from the clinic for failure to follow office policy.
9. There will be a $1.00 convenience fee with each transaction when paying by credit card.
10. For the safety of our patients and staff, no more than **4 people** (patient/family/guest) are allowed in the rooms at one time.
11. If for any reason there is a balance on a patient account, the account must be immediately paid in full. If an account is in bad debt or collection status, payment arrangements may be made as long as: a minimum of $50.00's a month is paid, a credit card (fees apply) is left on file so the account can be drafted automatically and approval from the clinic director has been secured.
12. It is the policy of this clinic that any refunds owed to you will be refunded not later than the 30th day after the date the overpayment was determined. It is the policy of this clinic that charges are not complete until the chart is reviewed and finalized by quality control. This is to ensure all charges documented are appropriate and meet Federal and State guidelines. I understand if I fail to pay any balance, my account will be turned over to collection as stated by the policy.

By signing this form, you acknowledge all the above listed polices and have had all questions answered regarding said polices.

By signing below I give permission for a picture to be taken for identification purposes in my child's and/or my chart.

By signing below I acknowledge that statements are sent electronically from this facility and I will only receive electronic statements sent to the email provided today. I understand this facility does NOT mail paper statements and it is up to me, the guarantor, to update my email address if it changes.

Parent or Guardian's / Patient's Signature Date