JC Peds - An Affiliate of Children's Mercy
1705 Christy Dr. Ste 210 Jefferson City, MO 65101
www.jcpedsdoc.com
Phone: (573) 606-7337 | Fax: (573) 616-4459

PATIENT DEMOGRAPHIC INFORMATION FORM			
First Name	Middle Name	Last Name	Suffix
Preferred Name	Date of Birth	Sex ☐Male ☐Female	
Race ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Other Pacific Islander ☐Prefer not to answer			
Ethnicity:☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		Language: ☐English ☐Spanish ☐Other_____	
PCP: ☐Dr. Hagely ☐Dr. Folz ☐Dr. Emslander ☐Dr. George ☐Other		Patient Cell (Ages 13-22):	
PARENT #1			
First Name:		Last Name:	
Relationship: ☐ Mother ☐ Father ☐ Stepmom ☐ Stepdad ☐ Legal Guardian ☐ Other _____			
Mailing Address:		Zip Code	
Cell Phone:	Home Phone:	Work Phone:	
Email Address:		Date of Birth:	
PARENT #2			
First Name:		Last Name:	
Relationship: ☐ Mother ☐ Father ☐ Stepmom ☐ Stepdad ☐ Legal Guardian ☐ Other _____			
Mailing Address:		Zip Code	
Cell Phone:	Home Phone:	Work Phone:	
Email Address:		Date of Birth:	
INSURANCE INFORMATION			
Insurance Name:		Effective Date:	
Policy Number:		Group Number:	
Subscriber Name:		Subscriber Date of Birth:	
Employer Name:		Patient Relationship to Subscriber:	
SIBLING			
First Name:	Middle Name:	Last Name:	Suffix:
Preferred Name:	Date of Birth:	Sex: ☐Male ☐Female	
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Other Pacific Islander ☐Prefer not to answer			
Ethnicity:☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		Language: ☐English ☐Spanish ☐Other_____	
PCP: ☐Dr. Hagely ☐Dr. Folz ☐Dr. Emslander ☐Dr. George ☐Other		Patient Cell (Ages 13-22):	
SIBLING			
First Name:	Middle Name:	Last Name:	Suffix:
Preferred Name:	Date of Birth:	Sex: ☐Male ☐Female	
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Other Pacific Islander ☐Prefer not to answer			
Ethnicity:☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer not to answer		Language: ☐English ☐Spanish ☐Other_____	
PCP: ☐Dr. Hagely ☐Dr. Folz ☐Dr. Emslander ☐Dr. George ☐Other		Patient Cell (Ages 13-22):	

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Consent for Medical Treatment

I allow the healthcare providers of JC Peds - An Affiliate of Children's Mercy to give the patient named below medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatment, and other medical services as determined by the provider.

I understand that, aside from emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction and I have consented to such procedure.

I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result of outcome.

Release of information for payment and assignment of benefits
I agree that JC Peds can share the patient's health information with the patient's health plan or other payment source in order to receive payment for services rendered. I hereby assign JC Peds the right to health insurance benefits otherwise payable to me or the patient on the account of the care provided, and I authorize such medical insurance benefits to be paid directly to JC Peds - An Affiliate of Children's Mercy.

I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Sharing Information Electronically
JC Peds may share information electronically with other healthcare providers involved in the patient's care. I agree that JC Peds can use these platforms to share the patients medical information.

I have been provided with a copy of the JC Peds Notice of Privacy Practices that describes other uses and disclosures of health information.

Acknowledgment
This approval will remain in effect until revoked in writing by the parent or legal guardian.

MINOR PATIENTS

Patient name _____Date of birth_____

Patient name _____Date of birth_____

Patient name _____Date of birth_____

Patient name _____Date of birth_____

Print Name Parent/Legal guardian: _____Relationship to patient: _____

Signature of parent/legal guardian: _____Date: _____

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HIPAA Acknowledgement & Release Form

Patient name _____Date of birth_____

Patient name _____Date of birth_____

Patient name _____Date of birth_____

Patient name _____Date of birth_____

We at JC Peds, are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have been given the opportunity to review the HIPAA Notice of Privacy Practices and understand that I may obtain a copy for my records upon request.

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (please check): _____Parent/Legal Guardian _____Self _____Other: _____

Consent to Authorize Medical Care

In the event a parent or legal guardian is unable to bring your child in for their medical appointment, please let us know who you give permission to seek medical care and treatment in your absence. This authorization also allows for medical advice to be given in person or over the phone. They will also be able to pick up necessary prescriptions, x-ray orders, lab orders or any other information necessary for the treatment and care of your child.

☐ I want only parents/legal guardians to receive information regarding my child's personal health information.

☐ I , _____, authorize the release of my child(ren)medical information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Name_____Relationship_____Phone_____

☐ Name_____Relationship_____Phone_____

☐ Name_____Relationship_____Phone_____

☐ Name_____Relationship_____Phone_____

By signing below, I acknowledge that I have read and understand the above policy.

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (please check): _____Parent/Legal Guardian _____Self _____Other: _____

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Vaccine Policy

At JC Peds - An Affiliate of Children's Mercy we prioritize the health and safety of all our patients by requiring vaccines, ensuring a protected environment for everyone under our care.

At JC Peds:

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children should receive vaccines mandated by the Missouri Department of Health and Senior Services for Childcare, Preschool and School requirements.

All of our providers believe that vaccinating your children may be the *single most important* health-promoting and life-saving intervention that you can perform as parents. Public health policy exists to promote the well being of all the children in our community.

JC Peds will not accept families that do not vaccinate their children. This includes both scheduled visits with our providers and walk-in appointments for our sick clinic.

JC Peds Vaccine Policy Requirements:

- All children must receive all vaccines recommended by the AAP that are mandated for daycare/school entry by the Missouri Department of Health and Senior Services.
- All children must begin receiving their immunizations at age 2 months and be up-to-date on all required vaccines by the age of 2 years.
- The following vaccines are recommended, but not mandatory at this time: Influenza, HPV vaccine, RSV vaccine, Rotavirus, Hepatitis A, Meningitis B.
- We currently do not carry the Covid-19 vaccine in our office. If you are interested in receiving this vaccine, please let your physician know.
- Parents or caregivers who choose not to follow the JC Peds vaccine policy will not be able to continue using JC Peds as their child's medical provider. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness, disability, or even death.
- JC Peds does not recognize alternative vaccine schedules (i.e one at a time, two at a time) unless medically indicated.

We prefer to remain your child's pediatrician and will not dismiss any family who is actively working to properly vaccinate their children. Our staff of doctors and nurses is here to help.

For more information please visit the following website: http://www.immunize.org

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (please check): _____Parent/Legal Guardian _____Self _____Other: _____

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Financial Policy

RESPONSIBILITY FOR THE BILL
It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the practice will file verified insurance for payments of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the practice in effect at the time of the appointment.

If you participate in a deductible plan and have not yet met your deductible in full, a $60 payment will be collected on any non-preventative services.

COPAYS AND HEALTHCARE LAWS
JC Peds would like to advise you on how healthcare reform may affect your copays at routine wellness exams and sick visits.

The healthcare law states that patients will no longer have to pay copays for routine wellness exams. Some insurance plans are "grandfathered in," which means a copay is still required for routine wellness exam visits. If your insurance plan requires you to pay a coinsurance or deductible, you may be billed for this balance.

However, copays and deductibles are still required for other services. If your provider addresses a specific health issue beyond the routine wellness exam, there may be an additional charge added to the wellness exam visit charge for the treatment of the illness, and you will be responsible for the copay portion of that visit. A routine wellness exam does not include a NEW medical problem that is happening now. The following are examples to provide clarification.

- **Example 1** An infant comes in for a routine wellness exam and immunizations. The infant also has a cold and fever and is found to have an ear infection requiring antibiotic treatment. The provider will bill for the wellness exam PLUS an additional charge for the ear infection and the parent will be responsible for the copay on the ear infection charge.
- **Example 2** A child is seen for a 5-year wellness exam. The child has ADHD and the provider determines the ADHD is not well-controlled and changes the patient's medication and provides a new treatment plan. The provider will bill for the routine wellness exam PLUS an additional charge for ADHD management and the parent will be responsible for the copay on the ADHD charge.
- **Example 3** A child with a history of asthma comes in for a routine wellness exam. The provider asks about the child's asthma and finds that it is well-controlled on the current medication and no changes are necessary. There will be no additional charge beyond the routine wellness exam charge and no copay is required.

If you participate in a deductible plan and have not yet met your deductible in full, a $60 payment will be collected on any non-preventative services.

ACCEPTANCE OF INSURANCE
We cannot bill your insurance company unless you give us your insurance information (copy of card.) Your insurance policy is a contract between you and your insurance company. We are not party to that contract.

If you do not have insurance that we participate with, you will be considered a self-pay patient, and full payment is expected at the time of service.

Our office cannot always tell you in advance whether or not our charges will be covered by your insurance plan. Each insurance company has multiple plans that vary with employer group contracts. Please be familiar with your own plan, including types of coverage and restrictions on x-rays, laboratories, and emergency rooms. While our staff is trained to assist you with your insurance questions, coverage limitations or policy restrictions can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

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BAD DEBT/LEGAL ACTION
If your account is not paid in full or satisfactory arrangements made within the allowable time frame, the practice reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance. In the event that your account is turned over for collection, in addition to the principal balance owed, you will be responsible for all legal, attorney, and collection agency fees.

BEHAVIORAL ASSESSMENTS & DEVELOPMENTAL SCREENINGS
In accordance with federal law and American Academy of Pediatrics guidelines, we offer early and periodic screening for behavioral and developmental health problems at all well visits. These screening questionnaires allow us to provide your child with the best possible care and are covered by most insurance providers. Please be advised that some insurance companies do not fully cover this assessment and you may incur a coinsurance or deductible amount for the screening.

ROUTINE VISION & HEARING EXAMS
Please be aware that we also perform routine vision and hearing assessments on our patients. These services may or may not be covered by your particular insurance plan. You also may incur a coinsurance and/or deductible balance for these services. If you do not wish to receive a hearing or vision exam, please inform our staff at the beginning of your visit.

COORDINATION OF BENEFITS
We will submit any non-covered services and/or deductibles to your secondary insurance, provided we are contracted with the payer.

MINOR PATIENTS
The adult accompanying a minor and the parents (or legal guardians) are responsible for full payment at the time of service. We are not party to any legal agreement between divorced or separated parents.

MOTOR VEHICLE ACCIDENTS & WORKERS' COMPENSATION CLAIMS
Worker's compensation claims must be authorized by your employer. Motor Vehicle Accident claims must be billed to the auto insurance carrier. At the time of your appointment, please be prepared to provide:

- Workers' compensation claim number or Auto Insurance Policy information
- Date of Injury
- Necessary claim forms
- For Worker's Comp: Name, address and telephone number of employer, immediate supervisor, and worker's compensation insurance carrier.
- For Motor Vehicle Accidents: Date and location of auto accident, Auto insurance policy info, other driver's policy info if being charged to the other vehicle's auto insurance

If a workers' compensation or auto insurance carrier denies a claim, you will be responsible for charges incurred as a result of the claim.

OUTSTANDING BILLS
The practice reserves the right to request deposits or payment in full for any outstanding balances. Deposits will be based on the outstanding balance plus the patient' share of the bill for the new service(s) to be performed.

PATIENT RECORDS, CORRESPONDENCE AND FORMS COMPLETION
Copies of medical records are available to the patient, parent, or legally appointed guardian, after we receive a signed release. Please allow 10 business days for completion of all medical record requests.

PATIENT RESPONSIBILITY
All patient account balances are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the practice. Not all services are covered by all insurance companies. It should be understood

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that by accepting the service(s), the patient/parent/legal guardian is responsible for payment regardless of whether the insurance covers the service. The practice cannot become involved with any third party liability matters and must always look to the patient/parent/legal guardian for payment of the bill. According to your insurance policy, you are contractually obligated to pay any copay due at the time of service.

Self pay patients will receive a 25% discount if the bill is paid in full at the time of service.

PAYMENT ARRANGEMENTS
The practice will make a reasonable effort to assist patients/parents/legal guardians in meeting their financial obligations. If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our office should you need to arrange a payment plan. This will avoid misunderstandings and enable you to keep your account in good standing.

POINT OF SERVICE COLELCTIONS
Payment for service is due at the time the service is rendered and non-emergency services may be deferred until the necessary payment arrangements have been made.

Payment will be accepted in cash, check, MasterCard, Visa, American Express or Discover.

RETURNED CHECKS
Any payment made by check that does not clear your bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each returned check.

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (please check): _____Parent/Legal Guardian _____Self _____Other: _____

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Patient Portal Consent

JC Peds provides established patients with a secure Patient Portal web site. This "portal" is intended to improve access to medical records and enhance patient-provider communications. Patients must be 18 years of age to access the portal and must sign-up with the front desk via this form at the time of their visit.

The Patient Portal allows for electronic access to view personal medical history, immunization records, view scheduled appointments and request medication refills. The portal is NOT to be used to communicate Urgent or Emergency issues. If you are experiencing an emergency please call 911.

Please read the following carefully:

- ALL communication via the Patient Portal will be included in your permanent patient record.
- The Patient Portal is being provided to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the Patient Portal at any time and for any reason.
- Staff members, other than your primary care provider, will be involved in receiving your messages, and directing them to the right person/place. These staff members will be designated and may be a medical assistant, nursing staff, billing clerk or front desk staff.
- It is your responsibility to protect your password from any one not authorized to access your information. If your password is stolen it is your responsibility to contact us and let us know. You agree to not hold JC Peds responsible for any violations beyond our control.
- Please refer to our Notice of Privacy Practices for information on how private health information is handled in our office.

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (please check): _____Parent/Legal Guardian _____Self _____Other: _____

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General Policies

APPOINTMENT MANAGEMENT

- **Arrival Time**: Please arrive 15 minutes prior to your scheduled appointment for check in, vital signs and screening.
- **Cancellation**: Please call 24 hours in advance of a scheduled appointment if you cannot attend, so this appointment may be offered to other children who need access to care.
- **Missed Appointment**: A missed appointment, or "no-show," occurs when a patient fails to give notice that the appointment cannot be kept or arrives after the appointment is over. Multiple (3) "no-shows" may result in termination from the provider and JC Peds. **NEW PATIENTS**: If you miss your first appointment and do not provide a 24-hour notice you will be discharged from our practice.
- **Late Appointments**: If you arrive more than 10 minutes late for your scheduled appointment, you may be asked to reschedule.
- **Follow Up**: Regular follow up appointments are required to refill long term medications.

SICK VISITS VS WELL VISITS OR BOTH?

- **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 a chronic problem.
- **Well Visit**: This is a visit for a routine physical exam or yearly health maintenance. Most insurance plans cover one well visit per year for patients over the age of 3.
- **Sick/Well Visit**: This is a combination visit of a routine physical exam where an acute or chronic issue is addressed as well. 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 IS IT 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 involved additional documentation as well.

HOW THIS AFFECTS ME: Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to pay two copays or have additional costs applied to his/her deductible.

ANNUAL PHYSICAL EXAMS: Annual physical exams target preventative care and are billed as such. **Medication refills and/or other ailments, injuries, or illnesses addressed during an annual physical exam are billed IN ADDITION to the annual physical. These charges may be passed on to the patient.** Please check with your insurance company to confirm your coverage for all types of doctors' visits.

We realize this can be confusing, and if you have any questions or concerns after reviewing this material, please ask.

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Patient name: _____Patient Date of Birth: _____

Parent/Legal Guardian Signature _____ Date _____

Relationship to Patient (please check): _____Parent/Legal Guardian _____Self _____Other: _____