The Youth Clinic
caring for our future generations

FAMILY CONTACT INFORMATION

---------- PLEASE COMPLETE THIS FORM IN BLACK INK ONLY ----------

Date _____ Account # _____

Children Names (First M.I. Last)	DOB	Gender	School	Goes By	Cell Phone #
		M / F			
		M / F			
		M / F			
		M / F			
		M / F			

Please use the email I have provided to enroll me for online access to health records for my child(ren) under 13.
☐ YES ☐ NO

Email Address _____

Mother's Name _____ DOB _____
First M.I. Last

Mother's Employer _____ Occupation _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Father's Name _____ DOB _____
First M.I. Last

Father's Employer _____ Occupation _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Patient Consent Form for Use and Disclosure of Protected Health Information
The Youth Clinic

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. As provided in our Notice, the terms of the Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting our information Privacy Officer at 970-416-6286, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

_____ _____
PRINT PATIENT NAME DATE OF BIRTH

_____
PRINT PATIENT PERSONAL REPRESENTATIVE NAME

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____
DATE OF SIGNATURE
This consent form references our Privacy Policies dated 4-14-03

*** PERMISSION REGARDING DISCLOSURE OF YOUR/YOUR CHILD'S HEALTHCARE INFORMATION ***

I hereby authorize The Youth Clinic to speak to the individual(s) named below regarding my/my child's protected health information (optional):

NAME: _____ Relationship to Patient: _____

NAME: _____ Relationship to Patient: _____

*** MAY WE LEAVE DETAILED HEALTH INFORMATION ON YOUR VOICEMAIL? ***

YES: ___ Phone Number: _____ NO: ___

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PATIENT INFORMATION AND CONSENT FORM

---------- PLEASE COMPLETE THIS FORM IN BLACK INK ONLY ----------

Date _____ Account # _____

Child's Name _____ Date of Birth _____
First M.I. Last

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Gender M / F

Religion _____

Race ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander

Language Is English your child's primary language? ☐ Yes ☐ No - Please specify _____

This information is required for Federal Vaccine Programs (VFC)

Child lives with ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Parents relationship to each other ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Are there any custodial restrictions we need to be aware of? ☐ No ☐ Yes - Please specify _____

Do we have a custodial agreement on file? ☐ Yes ☐ No - If no, please provide agreement to our office.

Other adults(s) involved in child's life

Name _____ Relationship _____
First M.I. Last

Name _____ Relationship _____
First M.I. Last

AUTHORIZATION FOR TREATMENT IN CASE OF EMERGENCY: In case of emergency, if I cannot be reached, The Youth Clinic has my permission to treat the members of my family as necessary.

_____ _____
Signature Date

update: 7/16/2013

THE YOUTH CLINIC MEDICAL FINANCIAL POLICY

The Providers and Staff of The Youth Clinic want to welcome you and your family to our Clinic. We want to make sure that every encounter you have with our Clinic from Patient Care to Billing is a positive and refreshing experience. In order to ensure this, we have prepared the following financial policies.

Your Visit

Please be prepared to do the following;

- Present your current insurance card at every visit.
- Be prepared to settle any co-pay or deductible. We accept cash, checks, and all major credit cards. A minimum of $75 towards your deductible will be collected at the time of service
- If you do not have insurance, a minimum of $75 towards visit will be collected at the time of service.

Cancelled Appointments

We require 24 hours notice for cancellation of any well care or medication check. We ask for one hour cancellation of any other appointment. If not given appropriate notice or your visit is missed, please reference the information below for charge assessment.

Missed Appointment	Assessed Charged
Nurse Visits	$10.00
1st missed appointment	courtesy notice
2nd missed appointment	½ of estimated visit charge
3rd missed appointment	full estimated visit charge presented to Medical Director for family dismissal

Complete Insurance Information

In order to file your insurance, we must have complete insurance information including:

- Insured's Name, Date of Birth and Employer information
- Group Number & Plan Address

All of the above information is listed on your insurance card which you will be asked to present at every visit. If you are unable to supply us with a valid insurance card, you will be in self-pay status until your information is provided.

Changes In Insurance Coverage

If you have a change in insurance coverage, it is your responsibility to make sure we have all of the pertinent information on file including effective dates. Any medical expenses not covered by your insurance plan will be billed to you.

Non-Participating Insurance Plans

If The Youth Clinic does not participate with your insurance plan several options are available.

- You may request an itemized statement from our Business Office and file the claim with your insurance company.
- The Youth Clinic can file a claim to your insurance company on your behalf.
- You may contact our Business Office to set up a payment arrangement at (970) 416-6271.

Newborn Insurance Coverage

If your child is a newborn, there may be a delay in the processing of claims. It is your responsibility to make sure your newborn child is added to your insurance. If you do not have your child added to your insurance plan, you will be considered a self-pay patient and payment in full will be expected from you.

Primary Care Physician

Many insurance plans require a Primary Care Physician be assigned to manage your child's healthcare. It is your responsibility to ensure you have chosen a Youth Clinic Provider as your child's Primary Care Physician. You may see any Provider at The Youth Clinic, regardless of your Primary Care assignment.

Insurance Payment Delays

The Youth Clinic is committed to partnering with its patients to resolve insurance payment delays. You may be called on to assist us in resolving issues with your insurance company. If we experience delays in payment beyond 60-days, you will be notified. It is important that you contact us immediately so we can resolve any issues and avoid holding you responsible for unpaid claims. Please call (970) 221-3489.

Coordination Of Benefits

Coordination of benefits will be the responsibility of the parent. The Youth Clinic will mail an insurance claim to your secondary carrier, but will not provide copies of the Explanations Of Benefits.

Responsible Parties

Parents who maintain custodial care of their children will be considered the Guarantor of the patient. Billing statements and other correspondence will only be sent to the address listed under the Guarantor. The Youth Clinic will not provide joint statements due to joint custody arrangements. Insurance information from other responsible parties may be added to the patient's account; however, payment of bills owed to The Youth Clinic will be the responsibility of the Guarantor.

Billing Statements

Statements are sent out by The Youth Clinic on a monthly basis. Any patient responsible balances due on your account may be reflected on your statement.

Returned Checks

A $10.00 service charge will be added to all returned checks.

Service Charges

If your account has a patient balance over 60 days old, there will be a $5 service charge added to your account monthly until the balance is paid in full.

Collection Letters

If you receive a collection letter from us, the most important thing you can do is contact us. We have courteous, helpful staff that can assist you in setting up satisfactory payment arrangements. Payment plans are available by contacting our Business Office at (970) 221-3489.

Collections/Termination

Balances not paid within ninety days will be reviewed for placement with an outside collection agency. Patients whose account is placed with an outside collection agency may be terminated from our practice. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (970) 221-3489 and requesting a reinstatement application.

Bankruptcies

Parents who file for Bankruptcy on behalf of patients attending The Youth Clinic may be subject to termination from the practice. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (970) 221-3489 and requesting a reinstatement application.

Medicaid Patients

Parents of Medicaid patients enrolled in a Primary Care Physician program must ensure that a Provider at The Youth Clinic is selected as the Primary Care Physician. Failure to do so will result in delayed or cancelled appointments until the situation is corrected. If The Youth Clinic is unable to verify eligibility, you may be asked to reschedule.

Phone Charges

As an extension of our total care, our Providers are committed to be available to patients by phone 24 hours a day. After hours phone calls or prescription calls to a pharmacy may result in a charge at the Provider's discretion. Even though the patient care occurred on the telephone, the Provider still takes responsibility for your child's healthcare at that time.

I have read and understand the above policies and agree to the terms outlined above. Failure to sign this Financial Policy will result in dismissal from our practice.

_____ _____ _____

Signature **Date** **Account #**