



Child Form

Cheyenne Location
 1919 Central Ave.
 Cheyenne, WY 82001
 (307) 514-9888

Laramie Location
 3810 East Grand Ave
 Laramie, WY 82070
 (307) 721-1794

Please use blue or black ink only

PATIENT INFORMATION

Child/Minor's First Name		Child/Minor's Last Name		MI	Preferred Name
Date of Birth	Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Parent/Guardian Name & Relationship
Address		Apt/Lot #	City/State/Zip		
Home Phone	Cell Phone	<input type="checkbox"/> check if parent's phone		Email <input type="checkbox"/> check if parent's email	
Emergency Contact Name (can be parent)			Phone		Relationship to PATIENT
Primary Care Doctor or Clinic			Preferred Pharmacy & Location		
<u>Race (optional)</u> <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other			<u>Ethnicity (optional)</u> <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino		
<u>How did you hear about us?</u> <input type="checkbox"/> doctor referral <input type="checkbox"/> relative <input type="checkbox"/> building signage <input type="checkbox"/> insurance directory <input type="checkbox"/> other <input type="checkbox"/> friend <input type="checkbox"/> phone book <input type="checkbox"/> mailer <input type="checkbox"/> newspaper <input type="checkbox"/> internet <input type="checkbox"/> billboard <input type="checkbox"/> radio ad <input type="checkbox"/> television					

GUARANTOR (PARENT/GUARDIAN RESPONSIBLE FOR SIGNING/PAYMENT)

Full Name & Relationship to PATIENT	Address (if different than PATIENT)	Date of Birth	Social Security Number
-------------------------------------	-------------------------------------	---------------	------------------------

INSURANCE INFORMATION

Full Name of INSURED	Address of Insured (if different than PATIENT)	Phone of Insured (if different)	Date of Birth of insured
Insurance Company Name	Policy Number	Group Number	Relationship to patient

DO WE HAVE PERMISSION TO:

Leave personal information on your voice mail, including but not limited to lab or other test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Discuss your medical information with family members?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(If Yes) Name	Phone	Relationship to PATIENT
Email you with updates & events from Stitches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly the physician. I understand that I am financially responsible for any balance. I authorize Stitches Acute Care Center, LLC or my insurance company to release any information required to process my claims. I also authorize the above communication permissions as checked, which will expire one year from date signed.

I, as the parent or guardian of above named patient, give consent to Stitches Acute Care Center, LLC, the physicians and other personnel on its medical staff, to administer such care, procedures and treatment that are deemed necessary and in the best interest of the patient. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved. I impose no specific limitations or prohibitions regarding treatment other than those that follow _____ (if none, leave blank)

PATIENT Name (Print)	Parent/Guardian Name & Relationship (Print)	Parent/Guardian SIGNATURE	Date
----------------------	---	---------------------------	------



PATIENT FINANCIAL POLICY

Welcome to Stitches Acute Care Center, LLC (SACC). We are committed to providing the best possible healthcare to you and your family. Understanding your financial responsibility is an essential element of your medical care and treatment.

INSURED PATIENTS: Our office policy is to collect the patient's responsibility for medical care provided at the time of service. We are here to help answer questions you may have regarding your insurance and payments. It is important to understand that your health insurance policy is a contract between you, your employer, and your insurance carrier. It is your responsibility to know what your policy benefits cover. We will collect your co-pay/deductible and file your claims directly to your insurance company. Deductible amounts are based on an estimate of your contracted rate. After your claim has been processed, you will receive a statement for any difference your insurance company applies to your responsibility. In the event your health plan determines a service is "not covered," you will be responsible for the balance upon receipt of a statement from our office.

UNINSURED/SELF-PAY PATIENTS: We understand that not all of our patients have health insurance coverage. Our office policy for self-pay patients is very simple: we utilize the same fee schedule for uninsured patients as we do for those with insurance. At the time of service we will collect payment in full for all services provided. Ask the front desk personnel for current estimated office visit costs.

PROMPT PAY DISCOUNT: We offer a 30% discount off our standard fee schedule for all charges paid in full by self-pay patients at the time of the visit. The prompt pay discount is a courtesy for payment IN FULL at the time of service, and does not apply to insurance discounted rates.

MEDICAID/CHIP: We do bill Medicaid for all Wyoming Medicaid patients. Co-Pay will be at the time of service.

MINOR PATIENTS: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent/guardian with custody for payments

Please be aware that if it is medically necessary for the physician to order blood work, you will receive a separate bill from the lab that the blood work is processed through.

We encourage you to call our billing office should you require assistance with your statement. A \$25.00 fee is added to your account if it is sent to collection and for non sufficient funds returned check fees.

I have read and understand Stitches Acute Care Center, LLC's FINANCIAL POLICY. I agree to be bound by its terms.

CHILD Name (Print)	Parent/Guardian Name (Print)	Parent/Guardian SIGNATURE	Date
--------------------	------------------------------	---------------------------	------

**LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS &
AUTHORIZATION TO RELEASE INFORMATION**

RELEASE OF INFORMATION: I authorize Stitches Acute Care Center, LLC (SACC) to release any third party payer or consulting physician any medical records concerning diagnosis and treatment when requested for its uses in connection with determining payment of services rendered and/or further treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT: I authorize payment directly to SACC for its services as described but not to exceed the reasonable and customary charge for service. I understand that my insurance may or may not be in-network with SACC and/or the physicians providing services. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third part within a reasonable period of time (not to exceed 60 days)

MEDICARE PATIENTS ONLY: I authorize payment directly to SACC and authorize release of medical information to the centers for Medicare and Medicaid Services (CMS) and its agents. In medicare-assigned cases, the physician agrees to accept the allowed charge determination of the Medicare carrier and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance & deductible are the determination of the Medicare carrier

I PERMIT A PHOTOCOPY OF THE AUTHORIZATION & ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT SACC: This assignment will remain in effect until revoked by me in writing. I understand that it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid by my insurance or third party payer. Should my check for payment be returned for any reasons, SACC will assess a \$25.00 return check fee to your account. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections. A \$25.00 fee will be added to your account if it is sent to collections.

CHILD Name (Print)	Parent/Guardian Name (Print)	Parent/Guardian SIGNATURE	Date
--------------------	------------------------------	---------------------------	------

PATIENT ACKNOWLEDGEMENT & CONSENT

The federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with HIPAA's requirements, we will provide you with a copy of our Notice of Privacy Practices upon request at any time. The Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out the treatment, payment activities, and healthcare operations as explained in our Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES: By signing this form, you acknowledge that you have been offered/given and have had an opportunity to read our Notice of Privacy Practices . Our notice provides a description of our treatment, payment and policies, healthcare operations, and your rights as a patient. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revision, at any time by contacting us at the above address.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation. You understand that the revocation of this consent will not affect any action we took in reliance on the consent before we receive the revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had a full opportunity to read and consider the contents of Stitches Acute Care Center, LLC's PATIENT ACKNOWLEDGEMENT & CONSENT and the NOTICE OF PRIVACY PRACTICES of Stitches Acute Care Center, LLC. I understand that by signing this consent form, I am giving my consent for Stitches Acute Care Center, LLC to use and disclose my Protected Health Information to carry out treatment, payment activities, and healthcare operations.

CHILD Name (Print)	Parent/Guardian Name (Print)	Parent/Guardian SIGNATURE	Date
--------------------	------------------------------	---------------------------	------