Rosenberg Center

BARRON PSYCHOLOGICAL SERVICES, PC

Child Registration Form

Date: _____

Patient's Information:

Patient Name (Print): _____ DOB: _____
Last Name First Name Initial

Gender: Female Male Child's Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Primary E-mail: _____

Parent/Caregiver's Name: _____ Phone #: _____

Second Parent/Caregiver's Name: _____ Phone #: _____

Parent Address (if different): _____ City: _____ State: _____ Zip: _____

Primary Pediatrician's **Name**: _____ **Clinic**: _____

Primary Insurance:

Primary Insurance Company: _____

Policy/ID #: _____ Group/Plan #: _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name (Print): _____ Relationship: _____
Last Name First Name Initial

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance:

Secondary Insurance Company: _____

Policy/ID #: _____ Group/Plan #: _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name (Print): _____ Relationship: _____
Last Name First Name Initial

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip: _____

Responsible Party: *(where should the patient's portion of the bill be sent, if not the patient?)*

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

Assignment and Release:

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

X_____ _____ _____
Responsible Party Signature Relationship Date

Rosenberg Center

Barron Psychological Services, PC

Consent to Treatment

I do hereby seek and consent to take part in the treatment by the providers at the Rosenberg Center and/or Dan Barron Psychological Services. I understand that developing a treatment plan with the providers as listed below and regularly reviewing our work toward meeting the treatment goals for my child are in my child's best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the providers at this facility.

I am aware that I may stop my child's treatment with the providers at this facility at any time. The only thing I will still be responsible for is paying or the services my child has already received.

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. For example, if there is an 8 am appointment scheduled on Tuesday, the cancellation must occur before 8 am on Monday. If I do not cancel and do not show up, there will be a $100.00 charge for each hour of scheduled time. This fee will not be submitted to insurance, but will be paid in full by the patient and/or patient's family.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and provider(s) of any service or treatments my child receives. I understand that if payment for the service my child receives here is not made, the providers at this facility may stop my child's treatment. I am authorizing any unpaid charges to a collections agency that is contracted with the Rosenberg Center and Barron Psychological Services.

I am aware this facility complies with Medical Records Standards Policies. The members of this facility will communicate freely with me about treatment options available regardless of benefit coverage.

My signature below shows that I understand and agree with all of these statements.

X_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Rosenberg Center: Assessment and Treatment for Children and Families
Amy Tannahill Medical Services
Barron Psychological Services, PC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services to use and disclose electronic protected health information and protected health information (ePHI/PHI) about me to carry out treatment, payment, and health care operations (TPO). This includes my authorization for the clinicians of Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services to *communicate between each other* about my child in an effort to facilitate diagnosis and/or carry out treatment. (The Notice of Privacy Practices provided by Rosenberg Center describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mae Petrangelo, privacy officer for the practice.

With this consent, Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.” With this consent, Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services may e-mail to my home or other alternative location any items that assist in the practice in carrying out TPO, such as appointment reminder cards or patient statements. I have the right to request that Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services restrict how it uses or discloses my ePHI/PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services to use and disclose my ePHI/PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or late revoke it, Rosenberg Center, Amy Tannahill Medical Services, and Barron Psychological Services may decline to provide treatment to me.

X_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient’s Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Rosenberg Center
Barron Psychological Services, PC
1935 County Road B2, Suite 100
Roseville, MN 55113

Financial Policy

We are committed to providing you with the best possible care. If you have insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

The preferred policy of Rosenberg Center and Barron Psychological Services is that full payment is due at the time of service. We accept cash, checks, and credit/debit cards. In the case that you have insurance, we will assist in processing claims on your behalf. If you would like us to submit insurance claims, we must have a copy of your current insurance card and signatures for release of information and assignment of benefits on your Registration Form. Failure to provide complete insurance information will result in the account being billed directly to you.

Since we are unable to keep track of every insurance plan and reimbursement options, you are responsible to know your level of coverage for the services provided by each clinician from whom you/your child obtains services from at our clinic. **If you have any questions regarding costs of treatment/evaluation, please ask the clinician prior to beginning services.**

If you have questions regarding your insurance coverage, co-payment amount, or deductible, please contact your insurance company directly, referencing your/your child's clinician at Rosenberg Center at the onset of treatment. Your policy is a contract between you, your employer, and your insurance company. Rosenberg Center and Barron Psychological Services are not a party to that contract. We do not assume responsibility for determining whether your insurance will cover services rendered.

A charge of $100 per hour scheduled will be made for missed appointments and appointments cancelled without at least 24 business hours advance notice. Missed appointment charges are billed to the patient, not the insurance company. Returned checks and balances older than 30 days may be subject to additional collection fees. Any account that is delinquent after 90 days may be sent to a collection agency. If you account is sent to a collection agency, you are also responsible for any collection and/or legal fees.

We must emphasize that as medical/behavioral service providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our clients. We realize that insurance and/or temporary financial problems may affect timely payments of your account. **If your insurance company denies payment for services for any reason, you are responsible for unpaid balances.**

If you have any questions are the above information, PLEASE do not hesitate to ask. We are here to help you work through issues related to your account.

When you see a clinician at Rosenberg Center and/or Barron Psychological Services, you accept full financial responsibility for all services that you/your child receive. If you have insurance, clinic staff and our billing service will assist you in obtaining reimbursement, but the ultimate responsibility is yours. The expectation is that you will make your payment or co-payment at the time of each appointment.

By signing this form, I acknowledge that I have read the financial policy of Rosenberg Center and Barron Psychological Services. By signing this form, I am agreeing to the financial policy of Rosenberg Center and Barron Psychological Services.

X_____ _____ _____
Patient/Legal Guardian Signature | Print Patient's Name | Date