TalkAbout inc.

Speech and Language Therapy
Occupational Therapy
1327 Kalakaket St Fairbanks, AK 99709
Phone 907-452-4517 Fax 907-452-4263

CHILD REGISTRATION FORM

CHILD'S NAME _____ **CHILD'S Date of Birth** _____ **M ☐ F ☐**
(Last, then First)

REGISTERING PARENT/GUARDIAN:

PARENT / GUARDIAN NAME _____ RELATIONSHIP TO PATIENT: _____
(Last, then First)

PARENT / GUARDIAN: Date of Birth _____ M ☐ F ☐ Social Security #_____

Mailing Address _____City _____ State _____Zip Code _____

Cell Phone # _____ _____ Email address_____

Employer _____Job Position / Title _____ Work Phone # _____

OTHER PARENT/GUARDIAN:

PARENT / GUARDIAN NAME _____ RELATIONSHIP TO PATIENT: _____
(Last, then First)

PARENT / GUARDIAN: Date of Birth _____ M ☐ F ☐ Social Security #_____

Mailing Address _____City _____ State _____Zip Code _____

Cell Phone # _____ _____ Email address_____

Employer _____Job Position / Title _____ Work Phone # _____

In case of emergency notify:
Name: _____ Relationship_____Contact Phone # _____

INSURANCE & BILLING INFORMATION

PLEASE COMPLETE INFORMATION FOR EACH INSURANCE COMPANY

Insurance Company	Primary Insurance	Secondary Insurance	Tertiary Insurance
Insurance Address			
Policy Or Group No.			
Family Members that are Covered			
Policy Holder's Name			
Policy Holder's Date of Birth			
Policy Holder's Soc. Sec. No.			
Relationship to Patient			

AUTHORIZATION: I understand full payment for treatment received is my responsibility regardless of my insurance coverage. I hereby authorize Talkabout Inc. to release to my insurance company any information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to Talkabout Inc. any benefits due to me for services that have not been paid in full.
This authorization shall expire upon written notice or one year after services have ceased.

_____
SIGNATURE DATE

_____
NAME OF PEDIATRICIAN: UPDATE

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CASE HISTORY QUESTIONNAIRE

Please fill out all areas: **Date:**

Name of Child: _____ Date Of Birth: _____
Address: _____
City: _____ Zip Code: _____
Phone: Home _____ Work _____ Cell _____
Does the child live with both parents? _____ Yes _____ No
Mother's Name _____ Mother's Occupation _____
Father's Name _____ Father's Occupation _____
Pediatrician: _____ Clinic: _____
Family Doctor: _____ Clinic: _____
Brothers and Sisters (include names and ages):
_____
_____

SIGNIFICANT HISTORY:

What is the problem/concern? _____
_____

When was it first noticed? _____
_____

What has been done about it? _____
_____

Is it worse at some times than others? _____
_____

Speech:

Does your child seem to have trouble understanding speech? _____ YES _____ NO

Does your child seem to enjoy listening to stories? _____ YES _____ NO

Can both parents understand your child's speech? _____ YES _____ NO

How does your child react when the following do not understand him/her?

Relative _____
Teacher _____
Playmates _____

Does your child talk _____Frequently _____Seldom _____Never

Is speech used meaningfully? _____YES_____NO

Which speech sounds does your child prefer to use? _____Complete sentences _____Phrases
_____Words _____Sounds

Is his/her speech accompanied by any unpleasant movements or facial expressions? _____YES _____ NO
Is the pitch of his/her voice _____ Too high _____ Too low _____ Too Soft _____Too Loud

Is the child's voice hoarse? _____ YES _____ NO

Are there any other languages besides English spoken at home? _____YES _____NO
If so, which language is it? _____

Does any other family member have speech difficulties? _____ YES _____ NO
Is YES, please explain _____

_____

_____

What questions are you hoping to have answered as a result of this evaluation?_____ _____

_____

_____

Speech/Language Milestones

During the first 5 months, other than crying, would you say your infant was:
A Silent Baby _____An Average Baby _____A Noisy Baby_____

Did your infant respond to noise? _____ If so, how?_____

_____

_____

At what age did he/she say first words?_____

Did he/she get one or two words and then go a long time before getting new words? _____YES _____ NO
At what age did he/she use word combinations like "want cookie" or "me out"?_____

At what age did he/she use more short, complete sentences?_____

Did speech learning ever stop for a period? _____ If yes, please explain_____

_____

_____

What efforts have been made to help your child talk better?_____

_____

_____

Has there been a change in your child's speech within the last 6 months? ____YES __NO

Better than 6 months ago? ____YES ____NO Worse than 6 months ago? ___YES ___NO

Does your child need to be urged to speak? _____ YES____ NO

Behavior

Does your child sleep well?_____YES _____NO

Does your child tend to play by himself/herself or with other children?_____

Are playmates the same age as your child? _____YES _____NO

Does your child have difficulty concentrating? _____YES _____NO

Is discipline difficult at home? _____YES _____NO

Check the traits that describe your child:

_____Easily makes friends _____Withdrawn _____Temper Tantrums

_____Uncooperative _____Cooperative _____Happy

MEDICAL HISTORY:

Is your child on any medications? If yes, identify: _____

_____

_____

Does your child have any allergies?_____ If yes, identify:

_____

_____

Birth History

Did the mother have any accidents, illnesses (German Measles, RH incompatibility, false labor) or other unusual complications during pregnancy? _____YES _____NO

If yes, please explain_____

Age of mother at child's birth_____Length of Pregnancy?_____

Birth weight of child_____

Were medications used during labor or delivery? _____ YES _____ NO

If yes, please explain

_____

_____

Was your baby incubated?_____ If yes, how long?_____

Did you infant have trouble starting to breathe? _____ YES _____No

Was your infant blue?_____YES _____NO

Was your infant given oxygen? ____YES _____NO

Was your infant jaundice?_____ YES_____ NO

Check the illnesses which your child has had and the child's age at the time of the illnesses:

Illness	Age	Mild	Mod.	Sev.	Illiness	Age	Mild	Mod.	Sev.
Adenoidectomy					Heart Problems				
Allergies					High Fevers				
Asthma					Influenza				
Blood Disease					Mastoidectomy				
Cataracts					Measles				
Chickenpox					Meningitis				
Chronic Colds					Mumps				
Convulsions					Muscle Disorder				
Cross-eyed					Nerve Disorder				
Croup					Orthodontia				
Dental Problems					Pneumonia				
Diptheria					Polio				
Earaches					Rheumatic Fever				
Ear Infections					Scarlet Fever				
Encephalitis					Tonsillectomy				
Headaches					Tonsillitis				
Head Injuries					Whooping Cough				

Illnesses/Age/Severity of Child at time of the Illness:

_____Gland Trouble _____Meningitis _____Other_____

Were any of the illnesses listed above followed by a noticeable change in your child's behavior or his/her speech and/or hearing abilities? If yes, please explain_____

Was your child ever hospitalized? For How Long?

If yes, please explain:

Has your child ever had any severe accidents? _____If yes, please explain:_____

PREVIOUS EXAMINATIONS AND TREATMENTS

Please specify: When_____Where_____and By Whom_____

Speech Evaluation_____

Speech Therapy_____

Hearing Evaluation_____

Ear, nose and throat_____

Medical_____

Dental_____

Neurological_____

Psychological_____

Feeding History

Does your child eat well?_____YES _____NO

What are his/her favorite snacks?_____

Did your infant have any of the following: _____Seizures _____Sores or Bruises
_____ Feeding problems _____ Swallowing Difficulties _____ Cleft lip or Palate
Was birth weight regained quickly?_____ YES _____NO

Does your child have any restricted foods?____ If yes, Describe_____

_____

Educational History:

School:_____ Grade:_____

How is the child doing academically (or pre-academically)?
_____Above average
_____Average
_____Below Average

Does your child receive special services? If yes, describe:

_____

_____

_____
Signature of Person Completing Form

_____
Date

_____
Printed Name of Person Completing Form

_____
Relationship to Child

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AUTHORIZATION FOR:

RELEASE OF INFORMATION
CONSENT FOR ELECTRONIC COMMUNICATION

Date:_____ **Child's Name:**_____

Date of Birth: _____

I am the Parent/Legal Guardian of _____ **and as such, I authorize the release of confidential information between Talkabout Inc. and each of the following that I have *initialed* next to:**

_____ **Fairbanks North Star Borough School District**
_____ **Tanana Valley Clinic**
_____ **Fairbanks Clinic**
_____ **Tanana Chiefs Conference**
_____ **Chief Andrew Isaac Health Center**
_____ **Bassett Army Hospital**
_____ **Eielson Air Force Base Clinic**
_____ **Health Net Federal Services**
_____ **Fairbanks Resource Agency (FRA)**
_____ **OTHER:** _____

_____ **Homeschool Program:** _____
_____ **Ak Center for Children & Adults (ACCA)**
_____ **Chena Health Center**
_____ **Orion Behavioral Health**
_____ **Village Health Clinic:** _____
_____ **Fireweed Pediatrics**
_____ **Providence Hospital (Anchorage)**
_____ **FACES Team**
_____ **Office of Child Services (OCS)**

Please INITIAL below, indicating your consent to receive SMS text/emails:

_____ **I consent to communication via SMS text/email.**

_____ **I understand that it may contain Protected Health Information and that SMS text/email is NOT a secure means of communication.**

_____ **I understand that Talkabout Inc. is not responsible for any charges incurred via SMS text/email communication.**

I understand that if I am <u>not</u> the biological parent of the above named child, I have submitted the appropriate legal documents to Talkabout Inc. to show legal guardianship.

I understand that information will be treated in a confidential manner. I also understand that is my right to request a copy of all information and contest any information that I feel is incorrect.

I understand that this form will remain in effect until it is revoked in writing.

Parent/Legal Guardian signature: _____ **Date:** _____

Email: _____ **Cell phone:** _____

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ATTENDANCE POLICY

In order for therapy to be successful, clients must attend on a consistent basis. Therefore, we have the following Attendance Policy in place:

After 3 consecutive cancellations, regardless if you have called in ahead of time to cancel, you will be removed from the clinician's schedule and placed back on the waiting list.

Even if you are calling in, if you are absent for more than 50% of your scheduled sessions at any given time, you may be removed from the clinician's schedule and placed back onto Talkabout's waiting list.

Regarding No-Call/No-Show appointments, after your second No-Call/No-Show appointment, you will be charged a $25.00 fee. This fee must be paid before therapy will be resumed.

Talkabout Inc. tries very hard to work with our clients on a personal level and understands busy schedules. However, speech, and occupational therapy are not successful if not completed on a continuum basis. Research has shown that therapy performed on a regular, consistent basis creates the most success.

PARENTAL ATTENDANCE DURING THERAPY:

It is not the policy of Talkabout Inc. to include parents in the therapy session. Your clinician will be glad to share with you daily notes, daily lessons and homework at the end of the session.

I understand Talkabout Inc.'s attendance policy, as well as the parental attendance during therapy policy.

SIGNATURE

Date

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Client's Financial Policy and Agreement

Your insurance policy is a contract between you (client) and your insurance company. As a courtesy to you, we will bill your insurance for the services provided. However:

- **Insurance companies often set reimbursement schedules that are lower than customary charges. The client may still be obligated for the full amount of our charges.**
- **The client may receive service(s) in which no benefit is offered by the client's insurance company. The client will still be responsible for these charges.**
- **It is the client's responsibility to ensure that the client's insurance and/or Medicaid is current. Charges will be the client's responsibility in the event that we cannot obtain payment from your insurance company.**
- **As a courtesy, Talkabout Inc. will attempt to request authorizations for Tricare clients. However, it is the Tricare client's responsibility to ensure that an authorization is in place covering each date of service, or the client will be responsible for the full amount of our charges.**
- **If an insurance company pays the client's claim, and subsequently requests the money back because they paid in error, it is still the CLIENT'S responsibility to pay these claims IN FULL. This is REGARDLESS of the reason why the insurance company recouped the money, and REGARDLESS of the amount of time that has lapsed between the date of service and the date of the recoupment request. Unfortunately, insurance companies are not bound by any time frame for recoupment.**
- **TALKABOUT INC. reserves the right to change fees without notification.**

Client's Payment Plan Agreement

- **If a remainder is owed after the client's insurance has addressed the claim, the client is responsible for the remainder. These remainders will be paid to Talkabout Inc. on a consistent, monthly basis, according to the terms below:**
  - ***When*? the first business week of the month**
  - ***How much*? Minimum 50% of the amount of your estimated monthly remainders, but you are welcome to pay more!**
    <u>For example:</u> If your remainder is $30 per session and your child is seen twice per week, your monthly remainder total would be $240.00 ($30 x 2x/week x 4 weeks per month). Since 50% of $240.00 is $120.00, your minimum monthly payment would be $120.00.
  - **If you have a large deductible, a minimum of $300.00 per month will be paid until your deductible has been met.**
- **These remainders will be paid at the front desk, prior to your child's first monthly appointment.**
- **If payment is not received within 30 days of the first monthly appointment, services will be suspended until payment has been received.**
- **PLEASE DISCUSS EXTENUATING CIRCUMSTANCES THAT WOULD PREVENT YOU FROM PAYING WITH THE OFFICE ADMINISTRATOR.**

I have read and understand Talkabout Inc.'s Client's Financial Policy. The signature below indicates that the client waives their right to be held harmless and agrees to assume <u>all</u> financial obligations for all services rendered, including any and all claims that may be denied by the client's insurance company for any reason. These include 1) uncovered benefits or 2) services that were determined by the insurance company as not medically necessary to receive assessment or treatment, or 3) any other denial reason. I agree that I, as the client or the client's parent/legal guardian, am ultimately responsible for all charges.

Signature of Person Completing Form	Printed Name of Person Completing Form	Date

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Informed Consent for Teletherapy

CONSENT FOR TELEHEALTH CONSULTATION **CHILD'S NAME:** _____

1. I understand that my child's speech- language pathologist and/or occupational therapist wishes my child to engage in a telehealth consultation.
2. I understand and consent to my child's Personal Health Information (PHI) being discussed through unencrypted email in order to initially set up telehealth service.
3. My child's speech-language pathologist and/or occupational therapist explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
4. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my child's health-care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I have had a **direct conversation** with my child's provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY TALKABOUT, INC.
Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. There is a simple link to follow by email. By signing this document, I acknowledge:

1. Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my child's provider and I may be in direct, virtual contact through the Telehealth Service, Doxy.me, does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Doxy.me Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my child's provider has access to any or all of the technical information in the Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my child's health care provider to have any of this information in the Doxy.me Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Printed Name Date

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Consent for Observation

_____, the parent or guardian of
(Name of parent or guardian)

_____, authorize Talkabout Inc.
(Name of child)

to allow a college student to observe the above named child during speech and / or occupational therapy for educational purposes.

This consent shall remain in effect for the duration of therapy sessions with Talkabout Inc., or until revoked in writing below.

_____ _____
Signature of parent or guardian Date

_____ _____
Date revoked Signature of parent or guardian

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NOTICE OF PRIVACY PRACTICES

EFFECTIVE SEPTEMBER 20, 2013
UPDATED MAY 1, 2017

This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

This Notice describes the medical information practices of Talkabout Inc. Talkabout Inc. is considered a covered entity, and therefore we are required by law to maintain the privacy of personal health information and to provide you with notice of our legal duties and privacy practices with respect to personal health information. All Talkabout Inc. departments or programs are covered by this Notice and your personal health information may be shared among these divisions.

Our Pledge Regarding Medical Information

We understand that medical information about your health is personal. We will not disclose your personal health information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records we maintain. It describes the ways in which we may use and disclose medical information, and describes our obligations with regard to such information. .

We are required by law to:
- Keep your protected health information private;
- Provide notice of our legal duties and privacy practices with respect to protected health information;
- Notify affected individuals following a breach of unsecured protected health information;
- Give you this Notice of Privacy Practices; and
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the personal health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling the Privacy Officer, David Jamison, at 907-452-4517, or by stopping by the Privacy Officer's office at 1327 Kalakaket St., Fairbanks, AK 99709.

How We May Use/Disclose Your Medical Information

The following are some of the different ways that we may use and disclose your personal health information:

For Treatment. We may use or disclose medical information about you to facilitate treatment, rehabilitation or treatment through services provided by Talkabout Inc. For example, we may disclose medical information to other healthcare providers who are involved in taking care of you.

For Payment. We may use and disclose medical information about you to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies (either directly or through a third party billing company), medical necessity determinations and reviews, and collection of outstanding accounts.

For Health Care Operations. We may use and disclose medical information about you for other Talkabout Inc. health care operations necessary to run Talkabout Inc. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; licensing; personnel training programs; fraud and abuse detection programs; and general Talkabout Inc. administrative activities.

To Business Associates. There are some services provided to Talkabout Inc. through contracts with business associates. Examples include accounting, legal, training, and consulting services. Information shall be made available to business associates consistent with their need to know for purposes of providing services.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Other Uses and Disclosures

We may also use and disclose your health information in the following circumstances, when permitted by law, and with only the minimum necessary information being disclosed:

- Appointment reminders
- Language interpreters
- Information about available treatments or products
- Funeral Directors/Coroners/State Medical Examiners
- Workers' Compensation
- Correctional Institutions (if you are in jail or prison)
- Law Enforcement
- Tissue and organ donation
- Disaster relief
- Military and Veterans (if you are an armed forces member)
- Responses to legally compliant court orders
- National security

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. This includes the use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing, or the sale of PHI, which will require your express written authorization.

Your Rights Regarding Personal Health Information

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to, or copies of, this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. If your records are held in electronic format, you may also obtain an electronic copy if it is reasonably available. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must provide a supporting reason, be made in writing, and be submitted to the Privacy Officer. If we agree to amend the information, we will generally amend your information within 60 days of your request and will notify you when we have amended the information

We may deny your request for an amendment if does not meet the requirements listed above. In addition, we may deny your request if you ask us to amend information that: is not kept by or for Talkabout Inc.; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures, where such disclosure was made for any purpose other than treatment, payment or health care operations. We are not required to give you an

accounting of information we have shared with our business associates or for which you have given us a written authorization.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years or before April 14, 2003. Your request should indicate in what form you want the list (i.e. paper or electronic). The first list you request within a 12-month period will be free, and you may be charged for the cost of any additional lists. We will notify you of the cost and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a transport or treatment we provided. We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment purposes) and the information pertains solely to an item or service paid for fully out of pocket.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must describe: (1) what information you want to limit; (2) whether you want to limit use, disclosure or both; and (3) to whom the limits shall apply, for example, your spouse.

Right to Request Confidential Communications. You can request that we communicate confidentially with you about medical matters. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate reasonable requests. Your request must specify how you wish to be contacted.

Right to a Paper Copy of This Notice. You may request a paper copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.

Right to Revoke Authorization/Permissions
If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Your substance abuse records received by a person or entity pursuant to your written authorization may not be re-disclosed without your written consent.

Questions/Exercising Rights

If you have any questions about this Notice or would like to exercise any of the rights contained herein, please contact: Talkabout Inc. Privacy Officer, David Jamison, 1327 Kalakaket St., Fairbanks, AK 99709.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Talkabout Inc. or with the Secretary of the Department of Health and Human Services. To file a complaint with Talkabout Inc., contact the Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against or penalized for filing a complaint.

The Secretary of DHHS can be reached at: Office for Civil Rights; U.S. Department of Health and Human Services; 200 Independence Avenue. S.W.; Room 509F, HHH Building; Washington, D.C. 20201.

I have read the Notice of Privacy Practices and understand my rights according to HIPAA.

Signature of Parent/Guardian

Date

Client's Name

Signature & Date of Staff receipt

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Please fill out highlighted areas completely

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

PATIENT AND INSURED INFORMATION

SECOND FOLD

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PLEASE PRINT OR TYPE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
WHCFA150032CS (4/05)

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)