Financial & Office Policies

Initial_____ **Authorization to treat**: I consent to examination and treatment by the personal at Dr Q Pediatrics for my child and other dependents. This will remain in effect from this date forward unless "written" revocation of such.

Initial_____ **Authorization to release information and Assignment of Benefits**: I hereby authorize the physician to release any information acquired in the course of my child's treatment necessary to process insurance claims. **Authorization to pay benefits to physician**: I hereby authorize payment directly to the physician for the services , if any otherwise payable to me for services render ,realizing that I am responsible for paying any copayment, deductibles and other fees not covered by my insurance carrier.

Initial____ _**Insurance Plans**: I understand that is my responsibility to confirm with the insurance company that the physician my child is scheduled with is currently under the contract with the patient's plan or be willing to have them be seen at "out of network". If the patient is not on an insurance plan or Dr Q Pediatrics provider/s are not contracted with the insurance they have, payment for any services will be paid in full at the time of service. Any questions about coverage on medical, well baby/preventive services, vaccines/immunizations, and labs should be directed to the patient's insurance carrier prior to their visits. It is my responsibility to know if a written referral or authorization is required to see a specialist and if preauthorization is required prior to a procedure for my child. I fully understand that not all plans cover or pay in full for wellness/child physicals and sick visit so I agree to be responsible for all copays, deductibles and non-covered services determined by the patient's insurance plans.

Initial_____ **Payments:** I guarantee that I will promptly pay all amounts that have been determined "patient responsibility" by my child's insurance company upon receipt of my statement. I understand that patient's health insurance contract is between the insurance companies and the subscriber of my child's policy. If the patients insurance's company does not pay for services rendered by the doctors at Dr Q Pediatrics within 60 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my child (ren)'s account after I have verbally requested it, in the event that the insurance

eventually pays. Any balance remaining after the health insurance pays, denies or deems non-covered under my child's plan will be my responsibility. If I have not paid my bill or have not arranged for a payment plan in the following 30 days after receiving the office statement a **late fee of $10** dollar will be added to the current balance. Accounts with balance exceeding 90 days incur a **late fee of $75 dollars**. In the event that the account balances is exceeding 120 days the practice reserve the right to discharge the family from the practice.

Initial_____ **Check in:** Copays, estimated co-insurances amounts, estimated deductibles amount, and past due balances are due at the time of the check –in. I understand that Dr Q Pediatrics accept cash, checks (under 200) an all major credit cards. A $35 fee will be charged for any returned checks, plus any banks fees incurred. I or whoever brings the patient in for services. (Exception can be made at Dr Q discretion).I agrees to bring the patient's current insurance card(s) at each visit, and will notify the practice of any insurance or demographic information changes. For all visits or at least twice a year Dr Q Pediatrics will ask to verify all the information on my child's account so that our records remain current. There is also a **convenience fee of $25 dollars** charge for the nurse visit appointment if patient is doing an alternative schedule or if the parents don't bring immunizations records with them.

Initial_____ **Appointments & Late arrivals:** I agree to have the patient arrive to appointments on time and understand if we are more than 10minutes late without calling appointment may be rescheduled for later that day if time permits, or may have to be rescheduled for another day. I further understand that Dr Q Pediatrics does **not accept** walk in appointment, if my child is brought in without a scheduled appointment he could be if time permit be seen at the end of the day or the next day.

Initial_____ **No Shows**: Patients who do not keep their appointment deprive others of an opportunity to see their doctor. DR Q Pediatrics requires prior notice for canceling any appointments. There will be a $35 no-show charge if they are not canceled 24 hours prior to the appointment time. I understand cancelations will need to be made with the office staff since they will not accept cancellations through their answering service after hours. **If more than 3 appointments are missed without notification, the practice reserves the right to dismiss the patient.**

I have read, understood and agree to the financial and office policies. By signing below I am aware that I will be considered the "Financial Guarantor" and will be responsible for any payment that becomes due as outlined above.

Parent/Guardian Signature:_____Date:_____

Please initial each item below and then sign and date at bottom

Patient Name:
Patient DOB:

Acknowledgement and authorizations:

.I have read and understand the HIPPA/Privacy Policy for Dr Q Pediatrics. _____

. I hereby assign my insurance benefits to be paid directly to the healthcare provider_____

. I Authorize Dr Q Pediatrics to release medical information required to process my claim_____

. I have read and understand the financial Policy for Dr Q Pediatric_____

.I authorize DR Q Pediatrics to obtain/release my medical records_____

.I authorize my provider's office to contact me by mobile phone_____

Signed _____Date _____

HIPPA Privacy and Release of information Authorization

I, _____hereby authorize DR Q Pediatrics and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number) for the purpose of helping me resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if; its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Released of Billing Information policy, Assignment of benefits policy, and grant the practice medication history authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof(e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient/Parent Printed Name Date Patient/Parent signature