

WEST SIDE PEDIATRICS

Parent/Guardian#1:

Last name _____ First name _____ Middle initial _____

Relationship to the patient: Mother Father Stepmother Stepfather Other _____

DOB: ___/___/___ SS# ___/___/___ Email _____

Home phone: _____ Cell phone: _____ Work phone: _____

I authorize messages that include Protected Health Information to be left on Home Cell DO NOT LEAVE

I authorize automated reminder calls to be left on Home Cell DO NOT LEAVE AUTOMATED REMINDER CALLS

Address: (where child/children reside)

Street: _____ City _____ State _____ Zip _____

Parent/Guardian#2:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to the patient: Mother Father Stepmother Stepfather Other _____

DOB: ___/___/___ SS# ___/___/___ Email _____

Home phone: _____ Cell phone: _____ Work phone: _____

I authorize messages that include Protected Health Information to be left on Home Cell DO NOT LEAVE

I authorize automated reminder calls to be left on Home Cell DO NOT LEAVE AUTOMATED REMINDER CALLS

Address: Same as Parent/Guardian #1 If not please list address here:

Street: _____ City _____ State _____ Zip _____

Please list all children:

Name _____ DOB: ___/___/___ male female SS# ___/___/___

Name _____ DOB: ___/___/___ male female SS# ___/___/___

Name _____ DOB: ___/___/___ male female SS# ___/___/___

Name _____ DOB: ___/___/___ male female SS# ___/___/___

Name _____ DOB: ___/___/___ male female SS# ___/___/___

Responsible party (must sign financial policy):

Same as Parent/Guardian #1 Same as Parent/Guardian #2 (If other, please complete below:)

Name: _____ Relationship to patient: _____

DOB: ___/___/___ SS# ___/___/___ Email _____

Home phone: _____ Cell phone: _____ Work phone: _____

Street: _____ City _____ State _____ Zip _____

PLEASE COMPLETE OTHER SIDE

Medical Insurance Information

Primary Insurance Name (i.e. Aetna, Humana)

Subscriber/policy holder: _____ Employer: _____

Policy # _____ Group Number: _____ Policy Effective Date: _____

Claims Address: _____ Co- Pay/deductible amount \$ _____

Secondary Insurance Name

Subscriber/policy holder: _____

Policy # _____ Group Number: _____ Policy Effective Date: _____

Employer: _____ Co- Pay/deductible amount \$ _____

Please answer the following questions:

Race:

- American Indian or Alaska Native
- Black or African American
- White
- Other _____
- Unknown
- I do not wish to answer

Primary Language:

- English
- Other _____
- I do not wish to Answer

Do your answers apply to all your children?

- Yes
- No

Ethnicity:

- Hispanic
- Non – Hispanic
- Unknown
- I do not wish to answer

Religion:

- Please List: _____
- I do not wish to answer

Do you require any interpreter services? Yes

**Please describe interpreter services that are required
(related to communication):**

Assignment & Release:

I give permission for West Side Pediatrics, or persons designated by them, to interview, examine and perform necessary laboratory procedures and to provide appropriate treatment to the above named minor. I further give my permission for evaluation and treatment whether the child is accompanied by a parent/legal guardian, other family member, unrelated party or is unaccompanied. I, the undersigned, assign directly to West Side Pediatrics all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible and have received the financial policy. I hereby authorize the use of this signature on all insurance submissions. I further authorize West Side Pediatrics to forward any information necessary, including, but not limited to medical records, to said insurance company for payment of my insurance claims as well as to other personnel to whom physicians of West Side Pediatrics have referred my child for treatment and to the admitting hospital should my child be admitted for treatment.

PLEASE NOTE: Whoever accompanies the child to each visit is expected to pay the charges due for the service rendered that day, including copayments, coinsurance, deductibles, etc. Divorce has no bearing on the responsibility for medical care as it affects third parties.

Name (print) _____ Signature _____

Relationship to patient(s) _____ Date: _____

FINANCIAL POLICY

Thank you for choosing West Side Pediatrics as your child's healthcare provider. We are committed to providing you the best quality medical care. We look forward to establishing a lasting relationship and partnership with you in caring for your child. As a part of this relationship, we wish to establish our expectation of your financial responsibility.

USUAL AND CUSTOMARY RATES: We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits. **You are responsible for payment regardless of the insurance company's determination of usual and customary rates. You are responsible for any balance remaining after your insurance carrier has processed the claim.**

INSURANCE COLLECTION: It is your responsibility to ensure that we have the most current copy of your insurance card, demographic and contact information. If your insurance is not verified at time of service, you will be responsible for payment at time of service.

CO-PAYMENTS: Payment is expected at time of service. Certain services are not covered by your insurance. For any questions regarding services/treatments, we encourage you to contact our Billing Manager and/or your insurance carrier to review costs. Failure to pay at the time of service will result in a \$15.00 service fee. As a convenience, we accept all major credit cards, debit cards, cash, and checks.

HIGH DEDUCTIBLE INSURANCE PLANS: Patients with high deductible plans will be required to pay \$50.00 at time of service for sick visits and consults. If there has been an overpayment, we will issue you a refund check

OUT OF NETWORK/NON-PARTICIPATING INSURANCE CARRIERS: If your insurance carrier considers us "out of network" or does not participate with us, you are responsible for payment in full at the time of service. We will gladly provide any proof of visit/receipts, etc.

WELL VISITS: Well child visits provide services to help keep children healthy, like a complete physical exam, measurements, developmental surveillance, vaccine counseling and administration, screening laboratory tests, hearing and vision, etc. These are preventative services. There may be times when a child needs a service that is not considered preventative, for example evaluation of a new illness / problem or a change in management of a known problem. This is a different service and is required to be billed to your health plan in addition to the preventative care service on that same day. If you have co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office has to charge you these amounts in accordance with the contracts that we have with your health plan. We value your time and want to make the most of each appointment for your child. This is why we offer the opportunity to address any problem that needs a provider's care during the well child visits so that only one trip is needed.

DIVORCE DECREES: In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. This office is not a party to your divorce decree. **We do not bill another individual or estranged spouse for payment.** Copayment is due at the time services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect from the other parent. West Side Pediatrics will not act as a mediator in collecting our payments.

PAST DUE PAYMENTS: It is expected that you will make every effort to pay your bill promptly. If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. Should collection action become necessary, the responsible party agrees to pay collection fees. No balance over \$300.00 can be carried on a family account without a scheduled payment plan.

PLEASE COMPLETE OTHER SIDE

West Side Pediatrics Patient Agreement

Initial _____ **INSURANCE PLANS/COVERAGE:** I understand it is my responsibility to confirm with my insurance company that the provider is currently under contract with my plan or be willing to be seen under "out of network" benefits. I further acknowledge that West Side Pediatrics is not responsible to know what services my insurance covers.

Initial _____ **WELL AND SICK VISITS:** I acknowledge that I have read and understand the policy on Well Visits. In addition, I acknowledge that I understand if extra time is needed during a well check for management of chronic conditions, or management of acute illnesses, or if a pre-op evaluation is needed, there are additional codes required on the insurance claim that may generate a co-pay or deductible balance, depending on my insurance plan.

Initial _____ **FINANCIAL COMMITMENT:** I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan at the time of my visit. If I have not come prepared to pay past due balances or co-pay, my child's appointment may be rescheduled for a later time. Furthermore, I understand that if someone other than me is bringing my child to West Side Pediatrics, they will be responsible to pay for copays and any past due balance. In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. This office is not a party to your divorce decree. **We do not bill another individual or estranged spouse for payment.** If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect from the other parent. West Side Pediatrics will not act as a mediator in collecting our payments.

Initial _____ **HIGH DEDUCTIBLE INSURANCE PLANS:** I am aware that I will be asked to **pay \$50.00 at time of service for sick visits and consults.** This amount will be applied to your balance and billed to your insurance plan. You will be billed for the balance of your visit once your insurance has determined benefits.

Initial _____ **DEMOGRAPHIC VERIFICATION:** I am aware that I will be asked to verify insurance and demographic information so records remain current.

Initial _____ **NO INSURANCE AT THE TIME OF SERVICE:** If insurance benefits cannot be determined, I understand that payment is required in full at the time of service. In some circumstances, I may have the option to put a credit card or debit card on hold until I am able to provide proof of insurance.

Initial _____ **PAYMENTS:** I commit to promptly pay all amounts that have been determined by my health insurance to be patient responsibility upon receipt of my statement.

Initial _____ **SERVICE FEES:** I understand my account will be charged \$25 for NSF/Returned checks.

Initial _____ **LATE ARRIVALS:** I have been made aware that if I arrive more than 15 minutes past my scheduled appointment time, the practice may have to reschedule my appointment.

Initial _____ **NO SHOWS:** I commit to give West Side Pediatrics at least 24 hours' notice if I am unable to keep my scheduled appointment. I understand West Side Pediatrics does not charge for no-shows; however, if I miss 3 appointments without notifying the practice in a 24 month period, the practice will no longer be able to continue providing pediatric healthcare services and I understand I will be dismissed from the practice. **(Note: this is per family, not per child)**

I have read, understood and agree to the above financial and office policy. I understand that **Non-compliance with this policy may result in a dismissal from West Side Pediatrics.**

Patient Name _____ DOB: _____

Patient Name _____ DOB: _____

Parent or Guardian's signature _____ Date: _____

WEST SIDE PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION BY PARENT OR LEGAL GUARDIAN

Patient's Name: _____ Birthdate: _____

I understand that it is the policy of West Side Pediatrics, Inc. (the practice) to protect my child's (listed above) privacy and to follow all state and federal privacy laws. However, I also understand in order to involve other individuals in my child's medical care it will be necessary for the practice to use/disclose some Protected Health Information ("PHI"). I understand that PHI to be disclosed may include information regarding genetic testing, HIV/AIDS status, mental health diagnosis and treatment, substance abuse diagnosis and treatment, pregnancies and/or pregnancy test results and I hereby specifically authorize the practice to disclose such information to the persons list below:

I authorize West Side Pediatrics, Inc. to release and discuss my child's PHI including test and procedures to the following individuals:

Name: _____ Relation to patient: _____ Date: _____

Name: _____ Relation to patient: _____ Date: _____

Name: _____ Relation to patient: _____ Date: _____

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release PHI. If I refuse to sign this Authorization, the practice will in no way deny me my rights concerning treatment.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice Manager with a written statement that I wish to revoke the Authorization. My revocation or Authorization will be effective immediately and PHI will no longer be used/ disclosed pursuant to this Authorization except when medically necessary in an emergency situation. This Authorization, unless I earlier revoke it, shall remain in effect for as long as my child is an active patient at the practice.

Parent(s) Name: _____

Signature: _____

Date: _____

Witness: _____