SWP SOUTHWEST PEDIATRICS

FINANCIAL & OFFICE POLICIES

Initial______ **Authorization to Treat:** I consent to examination and treatment by the personal at *Southwest 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 surgical and/or medical benefits, 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 it is my responsibility to confirm with the insurance company that the physician my child is scheduled with is currently under 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 *Southwest Pediatrics* providers are not contracted with the insurance they have, payment for any services will be paid in full at the time of service. *Southwest Pediatrics* does not accept patients with an HMO or government issued plans such as Medicare/ Medi-Cal. 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 authorizations is required to see a specialist and if preauthorization is required prior to a procedure for my child. I further understand that not all plans cover or pay in full for well-baby/child physicals, including any hearing, vision or other screenings typically done at physicals and if any abnormal findings are discovered during the physical it may result in paying a copayment/coinsurance. I agree to be responsible for all copays, deductibles, and non-covered services determined by the patient's insurance plan.

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 patient's insurance company does not pay for services rendered by the doctors at *Southwest 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 responsibilities. **If I have not paid my bill or have not arranged for a payment plan, the practice may ask for the assistance of an outside collection agency, if my child's account is turned over to a collection agency, my child and all dependents will be dismissed from the practice.**

Initial______ **Credit Card of File:** I understand that *Southwest Pediatrics* requires all parents to leave a credit card number, or Health Savings Account card number if applicable, with the office. I will further review this policy on the *Credit Card Consent Form* I will sign when I put my card information on file.

Initial______ **Check In:** Copays, estimated co-insurances amounts, estimated deductible amounts, and past due balances are due at the time of check-in. I understand that *Southwest Pediatrics* accepts cash, checks (under $200) and 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, will come prepared to pay at each check-in. If I do not come prepared to pay at my child's appointment, I may be asked to reschedule for a later time so that I may meet my obligation to pay. I agree 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, *Southwest Pediatrics* will ask to verify all information on my child's account so that our records remain current.

Initial______ **Appointments & Late Arrivals:** I agree to have the patient arrive to appointments on time and understand if we are more than 10 minutes late without calling a No Show Fee will be incurred on my child's account and their appointment may be rescheduled later that day, if time permits, or may have to be rescheduled for another day. I understand that any appointment my child is scheduled for *"after-hours"* or for *"emergency"* bases may have an additional fee associated with those services at that visit. I further understand that *Southwest Pediatrics* does not accept walk in in appointment, if my child is brought in without a scheduled appointment there will be *a $20 walk-in charge* due at time of visit, along with co-pays, coinsurance or deductibles.

Initial______ **No Shows:** Patients who do not keep their appointment deprive others of an opportunity to see their doctor. *Southwest Pediatrics* requires prior notice for canceling any appointments. There will be a *$20 no-show charge* for sick visit appointment and a $50 no-show charge for well child physical appointments 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 cancelations through their answering service after-hours. **If more than 3 appointments are missed without notification, the practice reserves the right to dismiss the patient.**

Initial______ **Minors:** I understand if my child is under the age of 18 a parent, guardian, or authorized person must accompany my child for all visits.

Initial______ **Service Fees & Indemnification:** I understand if my child has school, camp, sports forms etc. to be completed by *Southwest Pediatrics*, there is a $10 'form fee' charge . *Southwest Pediatrics* will have a 3-5 day turnaround time for forms to be completed and ready for me to pick up. If a form is needed sooner than 3 days, there is an additional $5 'rush from fee'. I also acknowledge if I request immunizations records for my child there will be a $5 processing fee if printed in the office. If I or whoever brings my child in, voluntarily separate vaccines from the well child/physical visit there will be a $25 charge for any additional appointment to receive the missed vaccines. I further agree that the practice will charge a $25 fee for requesting medical record on my child. I also agree to indemnify and hold harmless *Southwest Pediatrics*, its owners, officers and employees for any claims, lawsuits, causes of action, and/or damages of any nature caused by my breach of this financial policy, *Southwest Pediatrics* office policies, and for any claims made by the patient's insurance carrier regarding my child's account.

Initial______ **Authorization to release information:** I hereby authorize *Southwest Pediatrics* to send immunization, medication records and/ or routine physical forms to my child's school or other physicians at my verbal request.

Initial______ **Notice of Office Policies**: I am aware of the office policies of *Southwest Pediatrics*. I understand that I may view these policies on the website **www.swpediatrics.com,** or ask for a copy or explanation of the policies while in the office.

Initial______ **Notice of Privacy Practice Acknowledgement:** I, the undersigned, have received a copy of *Southwest Pediatrics*, NOTICE OF PRIVACY PRATICES as required by law. I am also aware that I may obtain a copy at any time online at **www.swpediatrics.com** and that I may obtain information by asking the front office staff any questions that I may have.

I, the undersigned, hereby authorize *Southwest Pediatrics*, its representatives, physicians, and staff to share any and all medical and financial information with the following individual(s). The individuals listed below have authorization to bring my child into that office for treatment. All copays, co-insurance or deductibles are due at the time of service.

Both parents will automatically have authorization unless **court documents are presented and specifically stating one is not authorized.**

❑ **At this time I do not want to authorize anyone other than parent(s)/guardian(s).**

Name: ________________________Relationship:___________________ Name: ________________________Relationship:___________________

Name: ________________________Relationship:___________________ Name: ________________________Relationship:___________________

Name: ________________________Relationship:___________________ Name: ________________________Relationship:___________________

I have read, understood and agreed to the above 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.

The patients that I am financially responsible are:

Patient Name: ____ DOB:________________

Patient Name: ____ DOB:________________

Patient Name: ____ DOB:________________

Patient Name: ____ DOB:________________

Patient Name: ____ DOB:________________

Parent/ Guardian Signature: _____________________________________ Date: ___________________

Relationship to Patient ____