Southeast Denver Pediatrics, P.C.
2121 S. Oneida Suite 200 Denver, CO 80224 – (303) 757-6418 – FAX (303) 757-2209
11960 Lioness Way Suite 200 Parker, CO 80134 – (303) 471-5060 – FAX (303) 471-5062

PLEASE INCLUDE ALL INFORMATION

Last Name	First Name	MI	DOB	Sex

PCP: ☐ Sagel ☐ Schwartz ☐ Miga ☐ Minick ☐ Kathryn, PA-C ☐ Rich, PA-C ☐ Sarah, PA-C

Name of friend/relative/emergency contact: _____
Phone: _____ Address: _____

☐ Father ☐ Mother ☐ other/relationship_____

☐ Insurance Subscriber ☐ Responsible for Bill

Name: _____

Address: _____

City, State, ZIP: _____

Home Phone: _____ DOB: _____

Driver's license: _____ State: _____

Social Security: _____

DAYTIME/CELL PHONE: _____

Employer: _____

Address: _____

City, State, ZIP: _____

Work Phone: _____ EXT: _____

☐ Father ☐ Mother ☐ other/relationship_____

☐ Insurance Subscriber ☐ Responsible for Bill

Name: _____

Address: _____

City, State, ZIP: _____

Home Phone: _____ DOB: _____

Driver's license: _____ State: _____

Social Security: _____

DAYTIME/CELL PHONE: _____

Employer: _____

Address: _____

City, State, ZIP: _____

Work Phone: _____ EXT: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Copay: _____
Subscriber Name: _____ ID/SSN: _____ Group: _____
Insurance company address: _____
Insurance company phone #: _____
Secondary Insurance Co. name: _____
Subscriber Name: _____ ID/SSN: _____ Group: _____
Insurance company address: _____
Insurance company phone #: _____

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.

INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to Southeast Denver Pediatrics for services rendered. I understand that I am financially responsible for any balance not covered by insurance.

Date: _____ Signature: _____

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Office Policies

In order to continue providing high quality medical care to your children, it has become necessary that we, the doctors at Southeast Denver Pediatrics, formalize our practice policies. Please review and sign this form prior to leaving the office today so that it may be included in your family's medical chart. We are happy to provide an additional copy for your records.

Well Child Exams:

Regularly scheduled "check-ups" are important in the medical care of your children. In addition to monitoring growth and development and providing vaccinations, these visits are intended to address your concerns. They are typically scheduled for 30 minutes and scheduled 6 to 8 weeks in advance.

1. **Rescheduling and Missed Appointments:** If it is necessary to cancel or reschedule an appointment, please do so as soon as possible. A $100.00 fee will be charged to those who do not provide 24 hours notice for the cancellation of a Well Child Exam (this includes Med Checks, ADHD Evaluations, and other regularly scheduled 30 minute appointments). A $50.00 fee will be charged to those who do not provide 24 hours notice for the cancellation of any other regularly scheduled appointments (this does not include same-day or next-day appointments). A $100.00 fee will be charged to those who do not provide 48 hour notice for the cancellation of a Therapy appointment. Also, because "No Show" appointments make it difficult for others to schedule Well Child Exams, three "No Shows" per family may result in dismissal from our practice.

2. **Late Arrivals:** Families and patients arriving more than 10 minutes late for their scheduled Well Child Exam may be asked to reschedule for a future date. Late arrivals for the check ups decrease the amount of time that we can spend addressing your concerns and create unplanned delays for patients scheduled later in the day.

Acute/Urgent Visits:

We try to provide accessible and timely medical care for patients who are ill. Visits are usually scheduled for 10 to 20 minutes depending on the anticipated complexity of the illness. Generally, these appointments can be made on a "same-day" or "next-day" basis.

1. **Emergency/Urgent Visits:** If your child is ill or injured, please call before coming in to the office. Patients who arrive without a scheduled appointment may be asked to wait or return for the next available appointment at the discretion of our medical staff. We do not set aside time for "walk-in" visits. Therefore, in order to ensure adequate time and attention for your child, it is best to have a scheduled appointment.

2. **Saturday/Holiday Visits:** Saturday appointments are *not* regularly scheduled office hours. We reserve Saturday visits for emergent patients only. There will be an additional charge if your child is seen in our clinic on a Saturday. There may also be an additional charge)per national coding guidelines) for appointments that occur on holidays (including but not limited to the day after Thanksgiving, Christmas Eve, New Year's Eve, etc.).

All Office Visits:

1. **Multiple Children and Siblings:** If you will have more than one child who needs medical attention at a visit, please tell the person scheduling your appointment. Even seemingly minor problems deserve the full attention of a scheduled appointment. "Add on" visits may be asked to wait or return for the next available appointment.

2. **Co Pays and Payments:** As a condition of many insurance plans, Co Pays for each child must be paid for each office visit at the time of service. It is your responsibility to know whether or not you owe a Co Pay. If it is not paid at the time of service, a $25.00 fee will be billed to you in addition to your Co Pay to cover the cost of additional processing. If you have questions regarding a bill, or feel that you may special payment arrangements, please contact our billing department as soon as possible.

3. **Delinquent Accounts:** Past due accounts will be assessed an annual fee of 18%. Failure to provide prompt payment on a past due account may result in that account being turned over to a collection agency. Any family referred to a collection agency will be dismissed from our practice. Following notification of dismissal from the practice, we will be available to provide emergency care for 15 days while a new primary care relationship is established.

4. **The parent or guardian who brings the child in for their appointment is responsible for payment independent of what a divorce decree may state. Both parents are responsible for payment at Southeast Denver Pediatrics. We will not intervene between parties; Reimbursement must be made between the two parents.**

5. **Children under the age of 18 must be accompanied by a parent or legal guardian at EVERY VISIT.**

By signing below I hereby give my consent for the use of telemedicine in my child's care.

If you have any questions or comments regarding these policies, please feel free to address them with our Practice Manager or Doctors.

I have read and understand the above:

_____ _____

Parent/Guardian Signature Date

_____

Patient Name

Southeast Denver Pediatrics	*Acknowledgement of Notice of Privacy Practices Form*	

I have been given a copy of this Office's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

Signature of Patient or Personal Representative

Patient Name

Name of Personal Representative (if applicable)

Date

For Facility Use Only: ***Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

Completed by

Signature of Facility Representative

Date

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Non Coverage Disclaimer

Dear Patient:

Your insurance policy may determine that a service is not covered benefit, of your health may process services as "out-of-network". Nevertheless, you and your physician may still believe that the service is important for your child's care and development.

Possible reasons for non-coverage by your policy are:

- A service is excluded from your individual policy.
- Your insurance company considers a particular service as "unnecessary".
- You do not have "routine benefits"
    - It is the patient's responsibility to make sure they have appropriate coverage for services provided.
    - Routine physicals are billed as such including all screenings and procedures that are recommended by the American Academy of Pediatrics, and may also include charges for services provided addressing any health problems or concerns that are presented at the time of/or in addition to the regularly scheduled exam.
    - If you do not have "routine benefits", you will be responsible for paying the balance for services rendered.

Out-of-network Health Plans

- If our office determines your health plan could be "out-of-network", and you still choose to have services performed by Southeast Denver Pediatrics, you may be responsible for the cost of the visit in full. Please verify your network coverage with your insurance or health plan prior to any regularly scheduled visit to prevent any delay or discrepancy in billing.

Immunization Non-Coverage

- **If the current policy you hold is under Kaiser, Tricare, Liberty Health Share, Medi-Share, Christian Care Ministries, or any other health share plan; your child's immunizations may not be covered.** If you choose to receive immunizations at our facility, you may be responsible for the entire cost without discount. Alternatively, you may visit a Tri-County Health Facility to receive any immunizations that may be required.

We are unable to appeal claims that have been denied as "non-covered" or "out-of-network" by your plan. If you have questions regarding billing, please contact our billing department or the Practice Manager. If you have questions regarding your coverage or the processing of a claim, please contact your insurance company.

Beneficiary Agreement:

I have been notified by my physician that my insurance company or plan may deny payment for services provided per the terms of my insurance policy. If my insurance company denies payment and assigns the remaining balance as "patient due"; I agree to be personally and fully responsible for payment. I understand that my physician's office is unable to appeal or re-bill any services that are denied due to non-coverage or "out-of-network" status. If the account is sent to collections, I agree to pay all collection fees, court costs and attorney's fees, with or without suit, incurred in collecting any past due balance.

_____ _____

Signature Date

_____

Printed Name

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Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information bay be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Consent to The Use of Telemedicine

I have read and understand the information provided about regarding telemedicine, have discussed it with my physician or such assistance as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize *Southeast Denver Pediatrics, P.C.* to use telemedicine during my diagnosis and treatment.

_____ _____

Signature of Patient (or person authorize to sign for patient) Date

_____

Relationship to Patient