

Fort Wayne Pediatrics Financial & Office Policies

Patient Name: _____
(First Name, Last Name)

DOB: ____/____/____

Patient Name: _____
(First Name, Last Name)

DOB: ____/____/____

Patient Name: _____
(First Name, Last Name)

DOB: ____/____/____

Patient Name: _____
(First Name, Last Name)

DOB: ____/____/____

Parent 1 Name: _____

Parent 2 Name: _____

Child(ren) reside(s) with _____
Names and relationships

Consent to Treat: I request and give consent to my healthcare provider to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my healthcare provider for my child's health and wellbeing. I hereby authorize the clinicians of Fort Wayne Pediatrics to provide vaccinations according to the AAP guidelines. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied up by me. I consent to the photographing of appropriate portions of my child's body for medical and medical record documentation purposes as long as such photographs are maintained and release in accordance with protected health information regulations. I consent to telehealth services as part of my child's treatment. I understand telehealth services include the practice of health care delivery, diagnosis, consultation, treatment of medical data and education using interactive audio, video or data communications. I understand medical or nursing healthcare providers in training may be observing and participating actively in my child's care under the supervision of authorized personnel. I give my consent to such observations and/or participation.

Communications: I give my consent and authorization for staff of Fort Wayne Pediatrics to leave protected healthcare information about my child on my answering machine/voicemail to the phone number I have provided. I also understand that by providing my phone number to Fort Wayne Pediatrics, I agree that Fort Wayne Pediatrics may contact me on that number using an automated telephone dialing system, prerecorded or artificial voice and/or text messages to my cell phone, or email messages to discuss my account, including current and possible future services, customer service, billing and collections. I understand these communicators are not encrypted or secure and I assume the risks of transmitting health information via unsecured means and are my financial responsibility for any and all charges incurred. I understand I may change my preferences at any time by submitting my request in writing to this office.

Financial Policy: The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by Fort Wayne Pediatrics.

- We will file insurance as a courtesy; however, you are ultimately responsible for your child's charges.
- It is your responsibility to bring your insurance card to every visit.
- Payment of co-pay and/or deductibles is expected from whomever brings the child to the appointment even if he/she is not the account guarantor. We are contractually obligated to collect, and you are responsible to pay, co-payments at the time of your visit.
 - For co-pays not paid at the time of service, an additional fee (currently \$15) will be added for the cost of billing you.
- You are responsible for payment in full for any medical care or services not covered by your insurance plan (this might include such things as screenings or services rendered outside standard business hours).
- It is your responsibility to
 - Ensure our providers actively participate with your insurance carrier
 - Know your child's benefit coverage prior to receiving services
 - Ensure all pre-approval requirements are met to avoid denials or out-of-network benefits
- You agree if your insurance company takes more than 60 days to respond to your insurance claim, we shall consider your services your financial responsibility and payment will be sought from you. It will be your responsibility to seek reimbursement from your insurance company.
- Collections: Accounts with a patient due balance over 90 days are subject to transfer to an outside collection agency resulting in dismissal from the practice. If your account is transferred to an outside collection agency, you agree to be responsible for all costs associated with the collection of the account, including reasonable attorney fees. Should your family be dismissed from the practice, you will receive written notification and given adequate time to find a new medical provider.
- Late fees: Balances are due upon receipt. If full payment (or call to set up a payment plan) is not made by the time a second statement is generated, you will be charged a late fee. To avoid late fees, you may establish a credit card on file with us. See Credit Card of File section for more details.

- **Returned checks:** If your check is returned by the bank for any reason, you will be charge a NSF fee (currently \$25) in addition to the amount of the check. We reserve the right to require all future payments be made by cash or credit card.
- **Self-pay patients:** If you don't have health insurance, we are out-of-network with your insurance or you are receiving a non-covered service, payment at time of service is required.
- **If new medical problem or pre-existing medical condition is addressed during a well visit,** the clinician may need to provide an additional office visit fee (referred to as a sick or ill visit) to provide proper care for your child. This is a different service and it is billed to your insurance company in addition to the bill for preventative services provided on the same day. If you have a co-payment for office visits, coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.
- **Treating minors without a parent or legal guardian present** is possible. In order to accommodate this request, Fort Wayne Pediatrics requires a signed and dated Authorizations for Medical Treatment of a Minor form when a minor is attending their appointment by themselves or is being accompanied by a person other than the birth parent or legal guardian for each visit. This form is available on our website, www.fwpeds.com.
- **Divorce decrees/rulings:** Our office is not party to your divorce decree. The guarantor on the child's account will be billed for services. We will not bill another individual or estranged spouse for payment. Both parents are responsible for payment of services provided by Fort Wayne Pediatrics. If your divorce decree required the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect from the other parent. Fort Wayne Pediatrics will not be placed in the middle for who is responsible for payment of medical care. Fort Wayne Pediatrics will seek payment/collections from both parents for outstanding balances.
- **No show fee** may be charged and you will be responsible to pay up to \$50 if 24 hours' notice of cancellation is not given for any appointment you are unable to keep. This fee will be directly billed to you and not your insurance company for payment.
- **If you 'no show' or do not cancel 24 hours prior to the appointment three times per FAMILY** in a calendar year, your family may be dismissed from the practice.
- **If you arrive more than 15 minutes late for your appointment,** you may be asked to reschedule the appointment.

Notice of Patient Rights and Responsibilities: I have been provided a copy of the Patient Rights and Responsibilities for Fort Wayne Pediatrics.

Notice of Privacy Practices: I have been provided a copy of the Privacy Practices for Fort Wayne Pediatrics.

Referral to Out of Network Providers Notice:

1. An out of network provider may be called to render healthcare items or services to your child during the course of treatment.
2. An out of network provider is not bound by the payment provisions or terms that apply to healthcare items or services rendered by a network provider under the covered individual's health plan.
3. You may contact your health plan before receiving healthcare items or services, or you may contact your health plan for additional assistance.
4. This notice is being provided to you in accordance with Indiana law. It is to notify you that healthcare items or services your child receives, from a provider that is out of network may cost you more than a provider who is part of your insurance or health plan's network of providers. If your healthcare provider refers you to a provider, contact customer service of your health plan or insurance company to determine your financial responsibility for services by an out of network provider and see if there is an in-network provider that may be available to provide the healthcare items or services at a lower cost to you.

Consent to release health information: I understand Fort Wayne Pediatrics uses an electronic medical record. I understand the electronic medical record contains information about my child's past, current and future healthcare. I agree this health information may be released through Fort Wayne Pediatrics' electronic medical record or by other means (fax, telephone, email, hand delivery or cloud-based platform) to 1) Fort Wayne Pediatrics, 2) to my child's past, current and future healthcare providers and other healthcare organizations that provide care to my child, 3) to the health insurance company names in my child's medical record; and 4) to any other person named in my medical record or insurance payers who pay for my treatment. These people may use my child's health information: 1) to treat me, 2) to get paid for my child's treatment (insurance companies for example) and 3) to do healthcare operations activities such as managing my child's care, providing quality care, patient safety activities, and other activities necessary to operate Fort Wayne Pediatrics. I understand these people will have access to all my child's health information in the medical record, including behavioral health and substance use disorder information (drug and alcohol treatment for example), my child's medical history, diagnosis and hospital records, doctor and clinic visit information, medications, allergies, lab test results, blood center information, donor insemination information, residential care facility records, pharmacy records, radiology reports, sexual and reproductive health information, communicable disease-related information and HIV-AIDS related information. I understand I may take back this consent at any time, except if the health information has already been released for these purposes. I also understand I may request a list of the healthcare organizations that have received my child's substance use disorder information. This consent will not expire unless I revoke.

The undersigned certifies he/she has read (or have had read to me) the forgoing, understands it and accepts its terms and has been offered a copy of. I hereby agree to all terms and conditions set forth above. Financial and office policies are subject to change at the discretion of Fort Wayne Pediatrics.

X _____
(Signature of biological parent, legal guardian or adult patient)

Date: _____