CHILD AND ADOLESCENT CLINIC
NOTICE OF PRIVACY PRACTICES AND FINANCIAL RESPONSIBILITY

Child's Name _____**Birthdate** _____**Pat #** _____

PRIVACY PRACTICES

I acknowledge that Physician's Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me.

Signature _____

Relationship to Patient _____ Date _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all fees, regardless of insurance coverage. Payment is required at the time or service unless other arrangements have been made in advance with the billing department. Child and Adolescent Clinic submits claims to a number of carriers. I will check with the receptionist to see if my plan is one of them. All other insurance claims are the responsibility of the family.

Co-payments and deductibles must be paid at the time of service. There is a fee charged for co-payments not made at the time of service. Any charges not paid by my insurance company within 30 days of the date of service will become the responsibility of the family.

PREVENTION: The Focus of your Child's Well Care Visit

Nearly all insurances have special "well care visits" that are fully covered as part of the Preventative Services benefit. Your child may have health issues or conditions that you/we are managing, but the focus of a Well Care Visit will be on avoiding future health issues and tracking developmental milestones. Well Care Visits include: review of medical history, risk assessment, screening tests, immunizations, and counseling on healthy behaviors. Well Care Visits typically do NOT include: evaluation of a new health issue, treatment of existing health conditions, lab tests or imaging for new or existing conditions, prescribing or adjusting medications, referrals to specialists, chronic disease management for asthma, ADHD, depression, etc.

Services not included in a Well Care Visit will need to be coded appropriately and submitted to your insurance plan. In this case, you could be billed for an Office Visit or diagnostic tests, as appropriate. This may mean that a copay, coinsurance, or deductible will apply. If you would like to keep these visits separate, we would be happy to schedule another appointment for a different date.

Your child's health is important to us and we want to address your concerns. We also want to help avoid any billing "surprises." For details on your coverage, please call your health plan's customer service department.

I have read the above policies. I hereby assign to the physician all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

Thank you for trusting us with the care of your child.

Updated _____
Scanned _____