SALUD PEDIATRICS | PARENT AGREEMENT

The parent agreement outlines a series of requirements that parents or legal guardians must commit and consent to for their children to become patients of Salud Pediatrics. The agreement includes office and financial policies. PLEASE READ IT CAREFULLY.

ANNUAL WELLNESS VISITS
As a patient of Salud Pediatrics, I commit to bringing my child to their age-appropriate check-up, including an annual wellness exam. I understand preventive visits foster partnerships among families, health care professionals, and communities. They also increase family knowledge, skills, and participation in health promotion and disease prevention activities.

RECURRING APPOINTMENTS FOR CHRONIC CONDITIONS
For patients with chronic conditions (i.e., asthma, allergies, ADHD), I understand I will be asked to set up recurring appointments in accordance with evidence-based clinical recommendations to ensure the patient's condition is properly monitored. If I am unable to make a reasonable effort to comply with the clinicians appointment recommendations, I recognize my child's prescription may not be refilled until an appointment is made.

VACCINE POLICY
I understand Salud Pediatrics adheres to the CDC & the AAP vaccination schedule. The practice does not accept patients whose parents refuse to vaccinate their children according to CDC and AAP guidelines.

IN-NETWORK
I understand it is my responsibility to confirm with my insurance company that Salud Pediatrics clinicians are in-network with my health plan before my child's appointment.

INSURANCE BENEFITS
I understand it is my responsibility to understand my insurance policy, coverage, and benefits. I will direct questions regarding my health insurance policy coverage to my insurance company.

PROOF OF INSURANCE
If insurance benefits cannot be determined, I understand that payment is required in full at the time of service. Under some circumstances, a credit or debit card may be put on hold until proof of insurance is determined.

CREDIT CARD ON FILE
I provide consent for Salud Pediatrics to keep my credit card on file (See CCOF Agreement for details). I understand the credit card on file will be processed after my health insurance plan has adjudicated claims.

CREDIT CARD PROCESSING FOR PATIENT RESPONSIBILITY
I authorize Salud Pediatrics to process my credit card for amounts assigned by my health insurance plan as patient responsibility according to the Explanation of Benefits. Charges may include but are not limited to: copayments, deductibles, coinsurance, out-of-network charges, and denied claims.

DEMOGRAPHIC VERIFICATION
To ensure that Salud Pediatrics records remain current, administrative staff will verify insurance and demographic information at every visit. This process also ensures billing accuracy.

COPAYMENTS | DEDUCTIBLES | COINSURANCE | OUT-OF-NETWORK
I agree to pay for all copays, deductibles, coinsurance, out-of-network, and any other non-covered services determined by my insurance plan. Unless a payment plan has been made, full payment is expected at the time of my visit. I understand that if I have not come prepared to pay for balances or have not made payment arrangements, Salud may reschedule my child's appointment.

DESIGNATED GUARANTOR
I understand that Salud Pediatrics does not accept a child's parent or legal guardian to designate another parent as the person responsible for financial obligations.

CREDIT CARD ON FILE, COPAYMENTS AND BALANCES AT THE TIME OF SERVICE
I understand that chaperones other than the patient's parent or legal guardian (grandparents, babysitter, etc.) are responsible for paying copayments or any past-due balance at the time of service. If Salud Pediatrics does not have a credit card of file, the accompanying adult must provide one for the patient's appointment.

Lastly, patients who are 18 or older and arrive without a parent or guardian must be prepared to pay a copayment, balance, or provide a credit card at the time of the appointment.

EMAIL NOTIFICATION REGARDING CREDIT CARD PROCESSING
Salud Pediatrics will send a notification to email or phone number on file regarding the amount that will be charged to my credit card. The notification will be sent 5 days before the credit card on file is processed.

STATEMENTS & PATIENT PORTAL
I understand that Salud Pediatrics does not mail statements in the presence of a patient balance. Transactions for dates of services, including insurance payments and adjustments are available on Salud's free patient portal.

TELEHEALTH SERVICES
Much like in-office visits, telehealth visits (which include phone consults, extensive portal messaging, and video conferencing) require clinician's time, expertise, and documentation and thus recognized as patient care. I understand that Salud Pediatrics charges for telehealth services as supported by the American Academy of Pediatrics and many health insurance companies.

LATE ARRIVALS
If I arrive more than 10-15 minutes past my scheduled appointment time, Salud Pediatrics may reschedule my child's appointment.

DELINQUENT ACCOUNTS
I understand if I have a past-due account with the practice (and no payment arrangement has been made) I will be discharged from the practice regardless of pending balance.

RETURNED CHECKS
I understand my account will be charged $45 for NSF/Returned checks

FORMS FEES
I understand Salud Pediatrics charges for forms not requested at the time of my visit. According to the Form Fee policy, the practice charges a "per-letter fee" for letters on company letterhead.

NO SHOWS
I commit to giving Salud Pediatrics at least 24 hours notice if I am unable to keep my scheduled appointment. If a cancellation occurs within 24 hours of my scheduled visit, the appointment is considered a "no-show." Salud Pediatrics does not charge for no-shows. However, the practice will dismiss families that have three (3) no-shows within 12 months.

MINORS
If a legal guardian does not accompany my child, I must provide written authorization before services can be administered. I also agree to be available by telephone should the clinician need to contact me.

I have read the parent agreement. I have clear expectations of what Salud Pediatrics requires of me as a parent/guardian. In addition to providing consent, I understand that Non-compliance with this policy may result in a dismissal of Salud Pediatrics.

Parent Name: _____

Signature: _____ Date _____

Sibling _____

Sibling _____

Sibling _____