FINANCIAL AND OFFICE POLICIES

Please read and acknowledge this form by initialing and signing where indicated. (Black ink only please)

Insurance Plans

- I understand it is my responsibility to confirm Island Coast Pediatrics is contracted with my insurance plan. If not, I am aware I could be responsible for "out of network" benefits. Questions about medical benefit coverage should be directed to my insurance carrier prior to my visits. I agree to be responsible for all co-pays, co-insurance, deductibles, and non-covered services determined by my insurance plan at the time of service.
- **I agree to provide accurate insurance information at each visit and I understand withholding insurance information may result in dismissal from Island Coast Pediatrics.**
- If I do not have proof of insurance coverage, I understand payment is due in full at the time of service.

Office Policies & Financial Responsibility

- I agree to bring my child's current insurance card and my photo ID with me at each visit, and keep my demographic information current.
- If I am unable to pay my co-pay or any balances due at time of service, my appointment may be rescheduled and I could be charged a **$25** billing fee.
- I understand I need to give 24 hours notice to cancel an appointment or **I will be charged a $50 no show fee**.
- Island Coast Pediatrics follows the recommended well care schedule of the American Academy of Pediatrics. We request physicals to be up to date and current per AAP's guidelines.
- I have been given a copy of the Island Coast Pediatrics' Patient Centered Medical Home & Patient Information Brochures.
- I understand that Island Coast Pediatrics will keep my **credit card information on file** and it is my responsibility to update it if that information changes. My credit card will be charged based on explanation of benefits provided by my insurance.
- Island Coast Pediatrics accepts Cash, Checks, Debit Cards, MasterCard, Visa, Discover and American Express. I understand my health insurance contract is between my insurance company and myself. If I am unable to pay my balances timely, I will contact the billing department to make arrangements.
- I understand that my insurance may not cover certain procedures and tests done during my child's well visit, and that I will be financially responsible for any charges that are not paid based on the contractual agreement with my insurance company.

HIPAA & Authorization to treat

- I acknowledge receipt of the Island Coast Pediatrics' Notice of Privacy Policy.
- If you wish to allow others access to your child's record (i.e. grandma, aunt, babysitter, etc), you must complete a "HIPAA Limitations" form. If you wish to restrict a parent from accessing your child's record, you must provide legal documentation.
- I consent to authorize Island Coast Pediatrics and affiliated physicians and allied health personnel to administer, diagnose and perform any medical exams, treatments and procedures that may now or during the course of the patient's care be deemed **advisable** and/or **necessary**.

Please list all children in your family that are current patients of Island Coast Pediatrics (incl. child being seen today).

1) Patient Name: _____ DOB: _____ 2) Patient Name: _____ DOB: _____

3) Patient Name: _____ DOB: _____ 4) Patient Name: _____ DOB: _____

I have read and understand the above Authorization to treat, Insurance, Office, Financial & HIPPA Policies.

_____ _____ _____

Parent (or Patient if 18 yrs) or Guardian's Signature **Date** **Reviewed by:** *(office use only)*