



## WELCOME TO OUR PRACTICE

We welcome you and your child(ren) to our pediatric practice. We aspire to give the type of care we would want for our own families: evidence-based, compassionate care in a timely manner and in an environment that fosters life-long relationships.

### OUR DOCTORS:

**Laura M. Laskonis, D.O.**, has been in practice here since 1997. She is a graduate of the University of Illinois and Chicago College of Osteopathic Medicine. She did her residency training at Rush-Presbyterian-St. Luke's Medical Center. She and her husband have three children.

**Melanie C. Lachman, M.D.**, has been in our practice since 2008. She is a graduate of the University of Illinois and the University of Debrecen Medical and Health Science Center. She did her residency training at University of Illinois-Chicago. She and her husband have three boys.

**Jessica M. Wyka, M.D.**, has joined our practice on July 12, 2021. She is a graduate of Georgetown University and Rush University Medical Center. She did her residency training at Rush Children's Hospital of Rush University Medical Center. She is married and has a daughter.

**Jessica Starck, M.D.**, has joined our practice on June 6, 2023. She is a graduate of Northwestern University. She did her residency training at Rush Children's Hospital in Chicago. She completed a pediatric emergency medicine fellowship at Lurie Children's Hospital. She and her husband have three boys.

**Matthew Root, M.D.** has joined our practice on July 18, 2023. He is a graduate of the University of Minnesota. He did his residency training at Vanderbilt University in Nashville. He is married and has two adorable dachshunds.

The doctors are board-certified by the American Board of Pediatrics, members of the American Academy of Pediatrics and are members of the medical staffs of Hinsdale Hospital and Anne and Robert Lurie Children's Hospital (affiliate staff).

### OUR STAFF:

Anne Kamba, R.N.

Eileen Gregg, R.N.

Christine Foster, R.N./Lactation

Rachel Laky, R.N.

Erica Ruiz, R.N.

Sara Obadi, R.N.

Mallory Brandel, R.N.

Christy Trovato, Biller

Donna Ruge, Office Manager

Crystal Salazar, Care Coordinator

Amie Kamba, Care Coordinator

Lisa Sanchez, Receptionist

Nicole Galindo, Receptionist

Michelle Wilson, Receptionist

Sue Ferraro, Receptionist



## **Welcome to All Star Pediatrics!**

We are glad you and your family have decided to join our practice.

Please let us know how you found All Star Pediatrics:

How did you hear about us?

Family Member                       Friend                       Social Media

Google/Internet Search                       OB/Doctor: \_\_\_\_\_

Other: \_\_\_\_\_

What attracted you to our practice? Check all that apply:

Our Doctors                       Extended evening and Saturday hours

Office Location                       In-house Lactation Consultant

Mental Health services                       Other:

\_\_\_\_\_

## **OUR OFFICE;**

Our hours are Monday through Thursday 8:00 a.m. – 7:00 p.m.

*(closed for lunch from 11:45 a.m. – 1:00 p.m., and dinner from 4:30 to 5:00 p.m.)*

Friday 8:00 a.m. to 4:30 p.m.

*(closed for lunch 11:45 a.m. to 1:00 p.m.)*

Saturday from 8:00 a.m. to 11:30 a.m.

Our phones turn on at 7:30 a.m. Monday through Saturday, 30 minutes before we open.

Well-child visits should be made in advance to accommodate your schedule. Same day sick child appointments should be made before noon if possible so we can plan the day, and please tell us if you plan to have more than one child seen. Please cancel appointments within 2 hours of your scheduled appointment and reschedule that same day if possible. **If you are more than 15 minutes late for your well child visit appointment, we will have to reschedule you.**

*All appointments must be scheduled, we do not take walk ins for well or sick visits. Children do not like to wait, so please help us keep on schedule.*

**AFTER HOURS:** Call 911 day or night for any life-threatening emergencies for which your child might require resuscitation. For poisoning, call the Poison Control Center at 800-222-1222. After office hours, calls should be made only for emergencies or urgent problems that can't wait until morning. Calls about mild illnesses can usually wait until the next morning and well child questions, prescription refills, etc. should be taken care of during office hours. Our patient portal can be used for nonurgent questions. We only answer these when we are in the office. Our office staff should return your call within 15 minutes; if you do not reach them or they do not call you back within 30 minutes please call them again.

Please have the following information available when you call; your child's main symptoms, your child's temperature if sick, your child's approximate weight, the name and dosages of any medicines your child is taking, your pharmacy's location (be sure it's open). Always have pencil/paper handy to take down instructions and have your child nearby in case you need to check something about his/her condition.

**BILLING** Full payment, including co-pays is requested at time of service (cash, check, Visa/Master Card/Discover). Our office submits insurance claims to every insurance plan that we are on. We are not on any HMO or Illinois KidCare plans. Please check with your insurance company before your first visit to make sure our practice is listed under your plan.

We hope to work with you to make parenthood a success and for you to have a healthy family, and we welcome any questions or suggestions you may have.

All Star Pediatrics, PC  
6410 Joliet Road, Suite 3  
Countryside, IL 60525 708-352-4448 (Fax) 708-352-1052

As of 1/1/21 we are mandated by your insurance company to collect social determinants of health which include race and ethnicity data. In addition we would like to update our database as to your preferred mode of contact from us.

Parent 1

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Home address: \_\_\_\_\_  
Best phone number: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent 2

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Home address: \_\_\_\_\_  
Best phone number: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Primary Language Spoken \_\_\_\_\_

Type to agree I agree that all telephone numbers and email addresses I have provided above may be used by All Star Pediatrics and those acting on its behalf to communicate with me by telephone, text, or any automated or prerecorded messages.

Children: ( if all categories are the same for children then please fill out only once and list all names below)

Names: \_\_\_\_\_

Ethnicity: <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to Answer	Race: <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Choose not to Answer
--	--

Children: ( if any children in your family have different race/ethnicity please fill out below , if you need more forms let us know) Names: \_\_\_\_\_

Ethnicity: <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to Answer	Race: <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Choose not to Answer
--	---

Please indicate your preferred method of contact for

**Appointment reminders** \_\_\_\_\_ **General information** \_\_\_\_\_ **Recalls/Newsletter** \_\_\_\_\_

INSURANCE:

POLICY HOLDERS NAME \_\_\_\_\_ SS# \_\_\_\_\_

If this person is a Step Parent, please give us their DOB \_\_\_\_\_

Per all Insurance Contracts all Co-payments are due at the time of service. It is your responsibility to be familiar with the specific rules of your plan. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines if you let us know at EACH appointment exactly what those guidelines are. If your insurance company is not one that we are contracted with, we will submit your claim however, no discount will be given.

I, the undersigned, acknowledge the child(ren) have insurance coverage with \_\_\_\_\_ and assign directly to the physician of All Star Pediatrics, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physicians at All Star Pediatrics, to release all information necessary to secure the proper payment of benefits. I authorize the use of this signature on all insurance claims.

Signature \_\_\_\_\_ Relationship to Child(ren) \_\_\_\_\_ Date \_\_\_\_\_

ALL STAR PEDIATRICS, PC  
6410 JOLIET ROAD  
COUNTRYSIDE, IL 60525  
708-352-4448

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male/Female

**Household – Social History:**

Parents Marital Status: Single Married Widowed Divorced Separated  
Any Former Marriages: Father – Yes/No Mother Yes/No

Please list all those living in the child's home:

Name	Relationship To child	Age	Step siblings or half siblings not living with them
_____			_____
_____			_____
_____			_____
_____			_____

Have any of your children died: \_\_\_\_\_

If mother and father are not living together or if child does not live with parents, what is the child's custody status:  
\_\_\_\_\_.

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home: \_\_\_\_\_.

Do you have any pets at the home? Yes/No Explain: \_\_\_\_\_  
Are there any smokers in the home? Yes/No Explain if Yes \_\_\_\_\_  
Are there any guns in the home? Unarmed, Locked? Yes/No Explain \_\_\_\_\_

**Birth History:**

Birth Place: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Apgar Score: \_\_\_\_\_  
Please circle any that apply: Natural conception, IVF, egg donor, sperm donor, adopted, Other \_\_\_\_\_  
Please circle: Was the delivery Vaginal or Cesarean? If cesarean why? \_\_\_\_\_  
Please circle: Was the baby born Full Term? Or early? If early how many weeks' gestation: \_\_\_\_\_  
Did your baby have any problems right after birth? Yes/No Explain: \_\_\_\_\_  
Please circle: Did you breastfeed or bottle feed? \_\_\_\_\_  
Did your baby go home with mother from the Hospital? Yes/No Explain \_\_\_\_\_  
During pregnancy, did mother Smoke? Yes/No Drink Alcohol? Yes/No  
During pregnancy, did mother use drugs or medications? Yes No. – What/When \_\_\_\_\_

**General:**

Are your child's immunizations up to date? Yes/No If No Explain \_\_\_\_\_  
Are you concerned about your child's health? Yes/No If Yes Explain \_\_\_\_\_  
Is your child allergic to any medicines or drugs? Yes/No If Yes Explain \_\_\_\_\_  
In times of stress, do you have support available? Yes/No

**Development:**

Have there been any developmental delays?  
Physical? \_\_\_\_\_ Speech? \_\_\_\_\_ Fine Motor? \_\_\_\_\_  
Are you concerned about your child's mental or emotional development? Yes/No Explain \_\_\_\_\_

**Past Medical History:**

Does your child have or has he/she ever had the following?

- Serious injuries or accident: Yes/No Explain: \_\_\_\_\_
- Surgeries (date, type) Yes/No Explain: \_\_\_\_\_
- Hospitalizations (date, reason) Yes/No Explain: \_\_\_\_\_
- Chickenpox Yes/No Explain: \_\_\_\_\_
- Frequent ear or sinus infections Yes/No Explain: \_\_\_\_\_
- Frequent pharyngitis/tonsillitis Yes/No Explain: \_\_\_\_\_
- Other infectious diseases Yes/No Explain: \_\_\_\_\_
- Allergic Rhinitis Yes/No Explain: \_\_\_\_\_
- Allergies to animals Yes/No Explain: \_\_\_\_\_
- Outdoor allergens Yes/No Explain: \_\_\_\_\_
- Indoor allergens Yes/No Explain: \_\_\_\_\_
- Lung Problems (wheezing/asthma/pneumonia) Yes/No Explain: \_\_\_\_\_
- Heart problems (murmur) Yes/No Explain: \_\_\_\_\_
- Frequent abdominal pain Yes/No Explain: \_\_\_\_\_
- Constipation requiring doctor visit Yes/No Explain: \_\_\_\_\_
- Reflux Yes/No Explain: \_\_\_\_\_
- Urinary tract infections Yes/No Explain: \_\_\_\_\_
- Bedwetting (after 6 yrs. Old) Yes/No Explain: \_\_\_\_\_
- Eye conditions/corrective lenses Yes/No Explain: \_\_\_\_\_
- Problems with ears/hearing Yes/No Explain: \_\_\_\_\_
- Any chronic skin problems (acne/eczema) Yes/No Explain: \_\_\_\_\_
- Anemia or bleeding problems Yes/No Explain: \_\_\_\_\_
- Blood transfusions Yes/No Explain: \_\_\_\_\_
- Frequent headaches Yes/No Explain: \_\_\_\_\_
- Convulsions/Seizures Yes/No Explain: \_\_\_\_\_
- ADHD/ADD Yes/No Explain: \_\_\_\_\_
- Orthopedic problems Yes/No Explain: \_\_\_\_\_
- Diabetes Yes/No Explain: \_\_\_\_\_
- Endocrine problems Yes/No Explain: \_\_\_\_\_
- (Girls)Has she started her menstrual period Yes/No Explain: \_\_\_\_\_
- (Girls)Are there problems with her period Yes/No Explain: \_\_\_\_\_
- Use of alcohol or drugs Yes/No Explain: \_\_\_\_\_
- Emotional problems Yes/No Explain: \_\_\_\_\_

Any other comments: \_\_\_\_\_



## **Statement of Financial Policies** **ALL STAR PEDIATRICS, PC**

Thank you for choosing our practice for your child's medical needs. We are committed to providing you with exceptional medical care, as well as, making our medical billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasing the patient's portion of the payment. This is driving many physician practices to adopt new financial policies to enable more efficient operational processes. Please take a moment to familiarize yourself with our practice's **"EASY-PAY"** - A Credit Card on File Policy.

To streamline our payment system and provide a convenient way for parents to pay their bills, effective August 1, 2019, we will require all patients keep an active credit card on file with us. The credit card information will be stored in a secure vault by our payment processor. We will bill your insurance company first and upon their determination of benefits we will charge your credit card for patient portion of the payment. Circumstances when your card would be charged include but are not limited to: missed co-payments, deductible and co-insurance, non-covered services and/or denial of services, and past due balances.

**Fee For Service:** We encourage all patients who have questions or concerns about the cost of care to inquire about those costs in advance of service. All Star Pediatrics follows the American Academy of Pediatrics, (AAP) guidelines for care provided to our patients. If deemed medically necessary, we will administer care according to those guidelines and patients will incur associated fees.

**Insurance:** We bill participating insurance companies as a courtesy to you. If you do not have insurance with which we participate, full payment is expected at the time of service. Your insurance policy is a contract between you and your insurance company. You have certain responsibilities such as presenting your insurance card at EACH VISIT and paying deductible and co-pays at the time of service. It is your responsibility to inform us of any changes in your address, phone number or insurance information so we can ensure that correct billing, eligibility and copayment requirements are accurate. If new insurance information was not given at the time of service any claim over 60 days old is your responsibility and must be paid directly to us. You are expected to know what the covered benefits are under your policy, including co-pays and deductibles. Our office cannot always tell you in advance whether or not your charges will be covered by your insurance plan. Because we have no way to know all the individual insurance policies, it is your responsibility to contact your insurance if you are concerned as to whether a charge is covered.

**Payment:** Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carriers does not provide payment within 40-60 days after treatment, you will be responsible for payment.

Once we determine your personal financial obligation or after your insurance company reimburses All Star Pediatrics, for a portion of your care, we will mail you one statement with the explanation of what is due. This amount will be charged in full to your credit card on file 10 days after the statement is sent. If the credit card is not active, we will send you a text message to reminder you to update your file at All Star Pediatrics with a credit card that is current.

**Financial Hardship:** We are not in the business of extending credit to our families. However we understand that there may be occasions when a family faces financial hardship. Please contact our office manager to make special arrangements.

**Outstanding Balances:** Any charges remaining unpaid 60 days after the date of services are considered past due. Past due accounts must make arrangements with the office manager prior to scheduling well child appointments. All accounts that have not made arrangements and are not being paid off will be sent to our collection agency.

---

Parents Signature

## Code of Conduct for Patients

To provide a safe and healthy environment for staff, visitors, patients and their families, All Star Pediatrics expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Questions about your billing can be addressed by our billing department.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

- Possessing firearms or any weapons
- Intimidating or harassing staff or other patients
- The use of profanity is prohibited at All Star Pediatrics. This includes in-person, phone, electronic or written communication.
- Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication.
- Physically assaulting or threatening to inflict bodily harm.
- Making verbal threats to harm another individual or destroy property.
- Damaging business equipment or property.
- Making menacing or derogatory gestures.
- Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

All Star Pediatrics, PC  
6428 Joliet Road, Suite 201  
Countryside, IL 60525  
(708)352-4448

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing at any time.

I further acknowledge receipt of the All Star Pediatrics, PC's Policies and Procedures and Statement of Financial Policies.

Our Notice of Privacy Practice can be found on our website at [aspeds.com](http://aspeds.com) under the New Patient tab or you may request a copy today by checking yes below.

- Yes, I would like a copy of the Notice of Privacy Practice  
 No, I would not like a copy of the Notice of Privacy Practice.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Print Patient Name: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_



**PATIENT PORTAL USER AGREEMENT AND INFORMED CONSENT**

Parent Information

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_ Telephone \_\_\_\_\_

Child's name: \_\_\_\_\_ DOB \_\_\_\_\_

Child's name: \_\_\_\_\_ DOB \_\_\_\_\_

Child's name: \_\_\_\_\_ DOB \_\_\_\_\_

Child's name: \_\_\_\_\_ DOB \_\_\_\_\_

Email address \_\_\_\_\_

Patient portal basics

All Star Pediatrics understands the need for communication between health care professionals and patients. All Star Pediatrics is committed to providing patients and other authorized personnel the ability to use a secure and confidential patient portal that provides the following functionality:

- 1. Access to medical records
- 2. Ability to contact the appointment desk.
- 3. Secure communication with health care professional.

The asped's portal utilizes technology to deliver secure communications between patients and All Star Pediatrics.

The term "patient portal" refers to the part of All Star Pediatrics' information system that provides access to patients' health information and allows for secure communication, including prescription, referral and appointment requests.

"Electronic communication" means e-mail or text messaging with patients outside of a patient portal.

Patient portal policy

The following policies and limitations apply to the use of All Star Pediatrics patient portal.

- 1. Patient portal communication is not for emergency purposes. If you are having an emergency, dial 911 or go to your local hospital.
- 2. Correspondence via patient portal is supplemental to physician/patient encounters. All Star Pediatrics will not provide patient portal-based diagnosis and treatment.
- 3. Sensitive subject matter, such as HIV/AIDS, STDs, mental health, behavioral health, drug treatment, or genetic testing information cannot be discussed through the patient portal.
- 4. Other electronic communication with the health care professional, such as non-patient portal email or text messaging is prohibited.
- 5. Communications sent via patient portal must be courteous, respectful, appropriate, fact-based and truthful.
- 6. Communications should be responded to within two business days. You agree not to use this portal if you need a response sooner or on an urgent basis. If your need is urgent you must contact the practice directly.
- 7. You agree not to share your password with anyone and that you are solely responsible for protecting your password.
- 8. You agree that access to the site is provided on an "as is available" basis and that our practice cannot guarantee you will be able to access the portal at any time. Internet based communications are inherently insecure since no technology guarantees privacy or security of information sent over the internet. You agree to use caution when providing information via this portal, and acknowledge that keeping messages secure is your responsibility.

Conditions of participation

Access to All Star Pediatrics is restricted to the above-named patient. This service is optional, and we reserve the right to suspend or terminate the service and/or your access to it at any time. If the practice suspends this service, you will still have access to copies of your medical record and other health information, upon request.

The patient acknowledges that he/she agrees to comply with the All Star Pediatrics, Patient Portal Policy outlined above.

Parents Signature: \_\_\_\_\_

ALL STAR PEDIATRICS, PC  
OFFICE POLICY (updated 07/17/24)

Our goal is to provide and maintain a good physician-patient relationship. Informing you in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial each section. If you have any questions, do not hesitate to ask a member of our staff.

**Appointments:**

1. We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we do require a 2-hour notice to cancel.
2. If you are late for your appointment (over 15 minutes), this will result in a "no show" charge. We will do our best to fit you into the schedule the same day but depending on the schedule we may have to reschedule your child's appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding,
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
5. Any portal or phone communication that requires medical decision making (photos to review, a change in medication, a new problem) will result in a telehealth or phone consult fee billed to your insurance.
6. We offer appointments on weeknights (after 5pm), weekends and holidays. Please note there will be a \$15.00 extra charge for these appointments.
7. No Show/Cancellation: Please give us the courtesy of 2 hours' notice to cancel your appointment. If an appointment is cancelled with less than 2 hours' notice or missed completely this will result in a \$100 charge per appointment missed for a Well Visit/ADHD/MOOD/CHRONIC ILLNESS and \$50.00 charge per missed appointment for a sick visit. The second no show may result in dismissal from our practice.
8. The last well visit (physical) is the summer of high school graduation. We will see children for 1 year after this date for acute care visits and continue chronic medication. One year after graduating high school our patients will need to transition to an adult provider.

Initial: \_\_\_\_\_

**Insurance Plans:**

1. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designated is incorrect, you will be responsible for payment of the visits and to submit the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regards to covered services and participating laboratories. For example:
  1. Not all plans cover annual healthy (well) physical, sports physical or hearing and vision screenings and surveys, you will be responsible for payment.
  2. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
3. It is your responsibility to know if a written referral or authorization is required to see a specialist.

Initial: \_\_\_\_\_

**Financial Responsibility**

1. According to your insurance plan, you are responsible for all co-payments, deductibles and coinsurances.
2. Co-Payments are due at the time of service. A \$5.00 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of the business day.

- 3. Self-pay patients will be given a Good Faith Estimate prior to the visit if we are aware of your self pay status. Payment is expected in full at the time of the visit. A \$5.00 service fee will be charged if not paid on that day and no arrangements are made prior.
- 4. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- 5. Patient balances are billed on the 15th of the month. On that statement we will let you know what day of the month we will be charging your credit card on file. If you have a problem with the bill please contact our billing department before that date. If you do not use your credit card on file, remittance is due within 10 business days of your receipt of your bill.
- 6. If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a \$5.00 rebill fee for each 28 day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency and you will be dismissed from the practice.
- 7. For scheduled appointments, prior balances must be paid prior to the visit.
- 8. If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card or a copy of a personal credit card to remain on file.
- 9. We accept cash, checks, Visa, MasterCard and Discover.
- 10. A \$15.00 fee will be charged for any checks returned for insufficient funds.

Initial \_\_\_\_

**Video or Audio Recording**

We do not allow video recording or audio recording of our staff members without their permission.

Initial \_\_\_\_\_

**Transfer of Records:**

- 1. If you transfer to another physician, we will provide a copy of your immunization records and last visit to the physician free of charge as a courtesy to you.
- 2. A copy of your complete record is available for a \$20.00 fee and a Transfer of Medical Records form will need to be completed.

Initial \_\_\_\_

**Prescription Refills:**

- 1. For monthly medication refills, we require 48 hour notice during regular business hours and you must be up to date with office visits. You may submit that request through the patient portal.

Initial \_\_\_\_

**I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.**

**Patient Name:** \_\_\_\_\_

**Responsible Party Name** \_\_\_\_\_

**Responsible Party Signature** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Date:** \_\_\_\_\_



## Vaccine Policy (updated 7/16/24)

It's important for our practice to maintain a consistent vaccine policy. We follow the recommendations from the American Academy of Pediatrics and the CDC. We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives, therefore we **REQUIRE** our patients to receive vaccines mandated by the STATE OF ILLINOIS. These include DTaP, IPV, Hib, PCV, Hep B, MMR, Varivax, MCV, Tdap.

### REQUIREMENTS:

- ***Baby vaccines need to be started by 6 months of age and completed by 24 months of age to be in compliance with our vaccine policy.***
- ***Kindergarten vaccines must be received by age 6 as required for entering kindergarten.***
- ***6<sup>th</sup> grade required vaccines must be completed by age 12.***

If you choose an alternative schedule, this "schedule" must be written, signed and agreed upon with the doctor in a contract. Each "shot only" visit will incur an administrative fee of \$25.00 per visit that is due at the time of your appointment. If you repeatedly cancel or reschedule your vaccine appointment, we reserve the right to discharge you from the practice.

If our approach doesn't align with your beliefs, we recommend seeking a healthcare provider who better matches your preferences.

Our routine vaccine schedule does include other vaccines that we recommend, but are not state mandated such as: Rotavirus, HepA, HPV, Men B, Flu, and COVID. Our schedule can be found on our website.

**I acknowledge that I have read the All Star Pediatrics Vaccine Policy.**

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date

Child(rens) Names & DOB: \_\_\_\_\_