Patient Name: _____

Patient Date of Birth: _____

*** I authorize this agreement to apply to all family members seen at Apple-a-Day Pediatrics: **YES / NO** (circle one) _____ (initial here)

Acknowledgement of Receipt, Understanding and Agreement with Notice of Privacy Practices (HIPAA)

I hereby acknowledge that I have received, understand, and agree to the provisions and declarations as provided and identified within the Apple-a-Day Pediatrics, S.C. Notice of Privacy Practices

_____

Signature Relationship Date

Consent for Treatment, Release, Assignments & Financial Agreement

I hereby request and consent to the provision of healthcare services from the above ("APA") primary care physician, other physician members within his or her APA group practice, and from non-physician healthcare professionals employed or otherwise retained within the practice. I authorize the practice, and any entities within Apple-A-Day Pediatrics S.C. to release any medical and other information in my medical or registration record to any entities or individuals having responsibility for authorization/payment for such healthcare services, for the purpose of determining eligibility and availability of health care benefits, and/or obtaining authorization/payment for such services. I agree that a copy of this authorization may be utilized as evidence of this authorization in place of the original. I agree that all telephone numbers and email addresses I provide may be used by Apple-a-Day and those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages. I further agree to irrevocably assign and transfer to Apple-A-Day Pediatrics S.C all rights to medical reimbursement benefits to which I am entitled for the purpose of the payment of healthcare service charges ("Patient Charges"), authorize payment of such benefits directly to Apple-A-Day Pediatrics S.C, guarantee payment of, and agree to be fully responsible for all Patient Charges to the extent that they are not satisfied by the assigned benefits.

_____

Signature Relationship Date

Continue to the back

Patient Name: _____

Patient Date of Birth: _____

*** I authorize this agreement to apply to all family members seen at Apple-a-Day Pediatrics: **YES / NO** (circle one) _____ (initial here)

Explanation of Payment for Services

Thank you for choosing Apple-a-Day Pediatrics as your healthcare provider. We are committed to your treatment being successful. Please understand that payment for your services is considered part of your treatment. Your clear understanding of our financial policy is important to our professional relationship. Please ask our cashier or billing representative if you have any questions about our fees or financial policy.

- A patient registration form must be completed prior to seeing the doctor.
- Payment is required at time of service. We accept cash, check and all major credit cards.

Usual and Customary Rates

Apple-a-Day Pediatrics S.C. is committed to providing the best treatment possible for our patients and we charge what is usual and customary for the Oswego area as determined by the major insurance carriers. You are responsible for payment regardless of any insurance company's determination of usual and customary rates unless otherwise dictated by a managed care contract.

Minor Patients

Minors must be accompanied by an authorized adult. Please provide them with written authorization (accompanied by a parent/guardian signature) for our medical staff to provide care. We will deny non-emergency care unless a minor presents us with such authorization. The adult accompanying a minor and/or the parents or guardians are responsible for payment.

Insurance

As a courtesy to our families, we submit all claims to your primary insurance company and accept assignment of insurance benefits. Families with managed care must pay their co-pay at the time services are rendered as stated in your benefits plan. For your convenience, we can apply co-payments to a major credit card with your authorization on file. If your insurance company has not paid the full balance within 45 days, then the balance of your account will be transferred to your responsibility. Please be advised that some (and perhaps all) of the services we render may be considered "non-covered" by your insurance company. In this case, they are not considered necessary and thus are not covered under your medical insurance plan. You are personally responsible for payment of these non-covered services.

Insurance is a contract between you and your insurance company. We are not a party to this contract unless you have a managed care plan. We request that you provide a credit card number with authorization to bill your account for any applicable co-payments and balances not paid by your insurance. You are responsible for the timely payment of your account. Failure to pay may result in further collection activity or dismissal from the practice.

Signature Relationship Date

Continue to next page

Patient Name: _____

Patient Date of Birth: _____

*** I authorize this agreement to apply to all family members seen at Apple-a-Day Pediatrics: **YES / NO** (circle one) _____ (initial here)

Cancellation and "No Show" Policy

Please help us serve you, and all our patients, best by keeping scheduled appointments.

Late Appointments: If you are 10 or more minutes late for your scheduled appointment time, you may be asked to reschedule. If two appointments are scheduled together, please ensure you arrive for check in prior to the FIRST scheduled appointment.

Missed Appointments: If you need to miss an appointment, please notify us 24 hours in advance or you will be assessed a $40 fee; this is considered a No Show. If you miss an appointment that you scheduled on the same day, and it is not due to a visit to the emergency room or urgent care, then you will be assessed a $40 fee.

In the event of 3 or more missed appointments/No Shows occur, we may ask you to seek services from another practice and/or be assessed a $50 fee.

I hereby understand and agree to the appointment Cancellation and "No Show" policy of Apple-a-Day Pediatrics.

_____

Signature Relationship Date

After Hours Policy

If you need to reach the on-call doctor regarding an *urgent* medical matter after regular business hours, please be advised that there may be a $25 charge if the call is not a result of an earlier office visit or if an office visit is not scheduled after the call. If you are calling for routine medical advice, appointments, or prescription refills, please call during normal business hours. If your call does require the physician's *immediate* attention, please dial the on-call pager at 630-392-4512.

I hereby understand and agree to the "After Hours" policy of Apple-a-Day Pediatrics.

_____

Signature Relationship Date

Continue to the back

Patient Name: _____

Patient Date of Birth: _____

*** I authorize this agreement to apply to all family members seen at Apple-a-Day Pediatrics: **YES / NO** (circle one) _____ (initial here)

Well Child Services Agreement

At Apple-a-Day Pediatrics, we understand the importance of regular well child visits to ensure proper health care for our newborn, infant, child, and adolescent patients. The doctors and staff follow the guidelines of the American Academy of Pediatrics (AAP) to maintain your child's health and safety. We protect our patients by following the vaccine schedule implemented by the AAP and performing the proper screening tests that are recommended at each stage of development.

Most insurance plans and policies cover preventative services. There are a few companies that have limitations on their coverage. Take the time to learn what services are covered for your children based on their age.

There may be times when a child needs an additional office visit service during a well-child visit. This additional service will be billed to the health plan in addition to the preventative service that was rendered at the same time. Some health plans require you to pay a copayment or deductible for these additional services. When an insurance company issues an explanation of benefits with patient responsibility, our office will bill you in the same accordance.

We understand the importance of your time and want to make the most of each appointment for your child. When time allows, we will address a concern that needs doctor's care during preventative exams to reduce the number of trips to the office. Some services that may be provided and billed in addition to the well child exam include:

- The doctor's work to address more than one minor problem (as noted above, an additional office visit service). Examples include ordering prescriptions, ordering tests, or changing the care plan for an established problem.
- Medical Treatments
- Procedures
- Testing outside the scope of AAP guidelines

Insurance billing is done in accordance with the services that are provided at the visit, so please do not be alarmed if you receive a bill for such services. We are happy to help if you have any questions.

I hereby understand and agree to the above terms of the Well Child Services Agreement.

_____

Signature Relationship Date