🍎 APPLE-A-DAY PEDIATRICS, S.C. 🍎

Patient Name: _____ **Patient Date of Birth**: _____

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. I may ask for a copy of this agreement at any time. (*attached on clipboard*)

Initial _____

Consent for Treatment, Release of Billing Information and Assignment of Benefits

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.

Initial _____

Financial Policy

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 receptionist or billing manager if you have any questions about our fees or financial policy.

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. Insurance is a contract between you and your insurance company. It is your responsibility to know your insurance plan benefits. You are responsible for the timely payment of your account. Failure to pay may result in further collection activity or dismissal from the practice.

Our responsibility to our families:

~ We submit all claims to your primary insurance company and accept assignment of insurance benefits.
~ We research information to process claims and answer questions about claims.
~ We issue paper or electronic statements once insurance has made their payment determination.
~ We accept payment by cash, check and most major credit cards.
~ We arrange payment plans when necessary. Total balance will determine the length of payment plan allowed.

→ **Continue to back**

Your responsibility to Apple-a-Day Pediatrics:
~ You provide eligible insurance information prior to each visit, notifying us of any changes. Failure to provide correct insurance information will result in charges being transferred to your responsibility.
~ You will notify us of any demographic changes.
~ You pay your copay at the time of service. If you cannot pay your copay at the time of service, a $10.00 fee may be charged to you in addition to the uncollected copay.
~ You pay any outstanding balances that are unpaid, denied or delayed by your insurance carrier beyond 60 days after the date of service. Nonpayment may result in services being withheld.
~ You will call your insurance company, if requested, to expedite payment for delayed claims before the 60-day limit has been reached.
~ You will call your insurance company when a submitted claim was denied. Denied and disputed claims do not suspend your requirement to pay for services rendered.
~ You will be responsible for deductibles and non-covered expenses. This may include charges for screening forms that are required by law or recommended by the American Academy of Pediatrics.
~ You will submit to Apple-a-Day Pediatrics any payment from the insurance company that is owed to Apple-a-Day.
~ You will pay a fee of $40.00 if a check is returned for insufficient funds.
~ You will file claims with your secondary insurance company, if you have secondary insurance. Any balance due after primary insurance has been billed is due immediately to Apple-a-Day Pediatrics.
~ You will pay in full for the office visit at time of service if insurance is not eligible or provided.

Divorced, Separated & Co-Parenting Parents:
The parent or guardian who brings the child in for medical services is the financially responsible party. If there is a financial arrangement between the individual parental parties, this arrangement is between the two parties and does not absolve the parent that brings the child in for services from their financial obligation to our office. OUR OFFICE WILL NOT BE INVOLVED WITH SEPARATION OR DIVORCE DISPUTES.

Minor Patients (anyone under the age of 18 years old)
Minors must be accompanied by an authorized adult. We have an Alternative Guardian Form that is required for an adult other than the parent or legal guardian to bring a patient into the office. We will deny non-emergency care unless a minor presents us with such authorization. The adult accompanying the minor and/or the parents or guardians are responsible for payment before or at the time of service.

Cancellation and "No Show"
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 Appointment***s:** If you need to miss an appointment, please notify us 24 hours in advance or you may be assessed a $40 fee; If you miss your appointment, this is considered a No Show and may be assessed a $40 fee. If you miss or cancel 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 may be assessed a $40 fee.

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

After Hours

If you are calling for routine medical advice, appointments, or prescription refills, please call during normal business hours, go online to schedule or use the patient portal to send us a message. If your call does require the physician's *immediate* attention, please dial the on-call pager at 331-220-5456.

Initial _____

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. **We do not accept new families who have made the decision to refuse or delay vaccinations into our practice, but we will work with you on an alternative schedule.**

Take the time to learn what services are covered for your children based on their age and your insurance plan. We recommended calling your insurance prior to wellness exams to know your benefits and coverage.

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:

- Diagnosis and Treatment of Acute Illnesses
    - Sick visits - if your child has a fever, sore throat, ear infection, or other symptoms of an illness
    - Injury Evaluation - assessment of new injuries, such as a broken bone or sprain.
- Chronic Condition Management
    - Refills/Adjustments - refilling or changing medications for ongoing conditions (i.e. asthma, allergies, or ADHD)
    - Chronic Care - detailed, in-depth evaluation of existing, stable or chronic health conditions.
- Extensive Diagnostics
    - Non-routine Lab Work - some screenings, like hemoglobin or lead, are standard, but specialized lab work - detailed blood chemistry panels, Vitamin D levels, or non-routine, comprehensive testing - is usually not included
    - Diagnostic Imaging - X-Rays, MRIs, or specialized imaging needed to diagnose a symptom.

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

_____

Signature **Relationship** **Date**