FINANCIAL POLICY & NO SHOW POLICY

To all of Our Patients:

Thank you for choosing us as your child's health care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered part of your child's treatment. **The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.**

FULL PAYMENT (for copays/deductibles or non-insured visits) IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, CREDIT CARDS (Amex, Discover, Mastercard & Visa).

Regarding insurance plans where we are participating provider, all co-payments and deductibles are due at the time of services are rendered. In the event that your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for full payment at the time of service. **You are responsible for payment in full if your insurance company for any reason declines payment or requests a refund on a previously paid claim.**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for** payment regardless of any insurance company's arbitrary determination of usual and customary rates. **You are responsible for** payment if your insurance company does not pay in a reasonable time (30) days for services rendered. You agree that should your child's account become delinquent, that you will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest at the rate of 18% per annum (1.5% per month).

For patients under the age of 18 **THE ADULT ACCOMPANYING THE CHILD** (including, parents, grandparents and babysitters) **WILL BE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.**

NO SHOW APPOINTMENTS:

Please call 24 hours in advance if you are unable to attend a scheduled appointment so that we may use the time slot for another patient. If you do not call within 24 hours or do not come for an appointment this is considered a no show. **WE WILL CHARGE YOU $35 FOR A NO SHOW APPOINTMENT,** and after 3 no shows for a scheduled appointment your child will be discharged from our practice.

NON-COVERED CHARGES:

Any charges not covered by your insurance company will be charged to you at the time of service, this may include any forms (including those needed for school registration), labs or diagnostic testing.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial and No Show Policy. I understand and agree to this policy.

Signature:_____ Date:_____

Name of person completing form (please print):_____

Relationship to Patient: _____ Patient's Name:_____

PATIENT DEMOGRAPHICS

please print clearly

Last Name: _____ First Name: _____ Middle____

Male Female Date of Birth:_____ Preferred language:_____

Race: _____ Ethnicity: _____

Primary Street Address: _____

City:_____ State:_____ Zip Code: _____

Primary Phone #:_____ Day Time Phone #: _____

Cell#: _____ Email Address: _____

Preferences for Contact Method: **Recalls:** No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

General: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

Portal: No Contacts, Text to Cell, Email

Reminders: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

Emergency Contact: _____ Relationship to Patient:_____

Phone #: _____

WHO HOLDS INSURANCE ON THE PATIENT: SELF MOTHER FATHER OTHER

Medical History:

Allergies: _____

Current or on going Medications: _____

Significant Medical Issues for the Patient: _____

Significant Medical Isuues for Family Memebers: Please list condition and relationship to Patient:

Anemia:_____ Epilespy: _____

Asthma: _____ HIV/AIDS: _____

Cancer: _____ High Blood Pressure:_____

Congential Anomolies: _____ Substance Abuse(specifiy):_____

Diabetes: _____ Thyroid: _____

Heart Disease: _____ Other (Specify) _____

Mother's information: DOB: _____

Last Name:_____ First Name: _____ Middle: ____

Primary Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #:_____ Day Time Phone #: _____

Cell#: _____ Email Address: _____

Preferences for Contact Method: **Recalls**: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

General: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

Portal: No Contacts, Text to Cell, Email

Reminders: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

Statements: Mail, Email

Patient live with: Mother, Father, Both, or Other

Father's Information: DOB: _____

Last Name:_____ First Name: _____ Middle: ____

Primary Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #:_____ Day Time Phone #: _____

Cell#: _____ Email Address: _____

Preferences for Contact Method: **Recalls**: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

General: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

Portal: No Contacts, Text to Cell, Email

Reminders: No Contact Mail, Primary #, Day # , Cell #, Test to Cell, Email

Statements: Mail, Email

Patient live with: Mother, Father, Both, or Other

ALTERNATIVE MAILING ADDRESS: _____

_____

Address belongs to: Mother, Father or Other

AUTHORIZATION FOR MEDICAL TREATMENT OF CHILD

The following individual(s) have my permission to obtain medical care at Naples Pediatrics, Inc.

For my child: _____
patient name

_____ ☐ I give permission for this person too
Name Relationship authorize vaccines for my child.

_____ ☐ I give permission for this person too
Name Relationship authorize vaccines for my child.

_____ ☐ I give permission for this person too
Name Relationship authorize vaccines for my child.

_____ _____
Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICES AND CONSENT TO DISCLOSE TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

Naples pediatrics will maitain the privacy of your Protected Health Information as required by law and by Notice of Privacy Practices currently in effect. I understand that a copy of the said privacy practices is available for me to obtain a copy if I would like. Are there other people beside yourself and in addition to those by law whom you authorize Naples Pediatrics, Inc. To discuss your child's protected Health Information ? If so please provide the following information:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Please state any limitations or restrictions on your consent to release Protected Health Information to the above named idividuals: _____

Please note that you may modify or revoike this consent in **writing** at any time unless Naples Pediatrics is acting or has acted in reliance on an existing consent from you.

Signature: _____ Date:_____

Relationship to Patient: _____