Kids First Pediatrics
Policies and Consent
(Revised Feb 1 2013)

Patient Name(s):

_____

_____

Please Provide Your Current Mailing Address:_____

_____

Please Provide Your Current Home Phone Number:_____

Please Provide Your Current Cell Phone Numbers:(Mom)_____

(Dad)_____

Our goal is to provide excellent pediatric services to our families. Letting you know in advance of our office policies allows for a good flow of communication and enables us to continue to provide the highest quality of services to our patients. ***Please read each section carefully and initial.*** 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 a well appointment, we require a 24 hour business day notice. **There is charge of $25 for missed well appointments or well appointments that are canceled without a 24 hour business day notice, and for missed sick appointments canceled without at least a two hour notice.** If a patient misses more than three sick or well appointments, Kids First Pediatrics has the right to terminate all services.
2) If you are late for your appointment (more than 15 minutes) we will do our best to accommodate you, however, on certain days it may be necessary to reschedule your 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. **Initial** _____

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance. All patients must present an insurance card (if applicable) when checking in. **If the insurance company you designate is incorrect you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) Some insurance companies require you to select a PCP and have that physician's name on the card. Please be aware of your insurance requirements. You will be financially responsible for the visit if it is not paid.
3) It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. **Initial** _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co- payments, deductibles and co-insurances.
2) Co-payments are due at the time of services.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.

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) Patients with an outstanding balance of more than 90 days overdue, who do not have a payment plan, must make arrangements for payment prior to scheduling appointments. **Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason.** Any balance outstanding longer than 90 days will be forwarded to a collection agency unless prior payment arrangements have been set up with our office.
6) We accept cash, checks, and credit cards.
7) A $25 fee will be charged for any checks returned for insufficient funds.
8) **You are responsible for paying any nominal fees for forms.** **Initial** _____
9) You agree, independent of all other requirements, conditions, or obligations, that you provide us with your prior express consent to receive telephone calls to your provided telephone numbers (cellular or otherwise) from us or our representative by means of an automatic dialer and/or pre-recorded artificial voice messages. **Initial**_____

Permission to Bill for Services
I understand that Kids First Pediatrics will perform services in which they will need to bill my insurance company and/or myself. I certify that the insurance information I have provided is true and accurate to the best of my knowledge. I hereby give permission for Kids First Pediatrics or their designee to provide any and all necessary information to my insurance company to be reimbursed for service provided. I assign directly to Kids First Pediatrics all insurance benefits, if any otherwise payable to me for services rendered. I further understand that any portion of services not paid by my insurance company is my financial responsibility and I agree to pay when due.
Initial _____

Permission to Contact
I hereby give Kids First Pediatrics or their designee the right to contact me concerning any billing or payment issues. I understand that this may be by mail, email, phone (including cellular) or other general accepted form of communication. I understand when I provide Kids First Pediatrics a wireless telephone number or land line number that I am giving them my prior express consent to call that number.
Initial _____

Transfer of Records
1) All requests for medical record release/transfer **MUST** be submitted in writing as per NC law and accepted healthcare guidelines. Please allow 3 business days for processing of such requests.
2) A copy of your complete record is available for a $20.00 fee/record. **Initial** _____

Prescription Refills
1) For all medication refills we require a **48 hours** notice. Please plan accordingly. **Initial** _____

Vaccine Policy
I hereby acknowledge and understand that Kids First Pediatrics strictly adheres to the American Academy of Pediatrics schedule for vaccines. I have been given a copy of the Vaccine Policy and understand that the practice **will not** deviate or honor any alternative vaccine schedule.
Initial _____

Notice of Privacy and HIPAA
I acknowledge that I have been provided with information about Kids First Pediatrics' privacy and HIPAA policies. I understand these policies and my rights, and the uses and disclosures of my information. I understand that Kids First Pediatrics reserves the right to change its policies and I may ask for a copy of these changes at each visit.

By signing this form, I consent to each of the paragraphs above and Kids First Pediatrics' right to use and disclose my health information for treatment, payment and health care operations.

Patient/Guardian Signature: _____ **Relationship** _____ **Date**_____