TREATMENT CONSENT AND DISCLOSURE

I hereby voluntarily agree to diagnostic procedure(s) and medical and surgical treatment(s) which may be administered to or performed on the patient(s) listed below, under the general or special instructions of the attending practitioner's care and service, or the practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the result of the treatment at this office. I understand that my attending practitioner encourages me to ask questions and voice concerns about medical care or services and that asking questions and voicing concerns will not compromise my care.

X Signature: _____ Date: _____

*********PLEASE LIST ALL CHILDREN*********

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB _____

PLEASE LIST THE HOSPITAL WHERE CHILD WAS BORN IF YOUNGER THAN 4 WEEKS: **_____**

*********PARENT/GUARDIAN INFORMATION*********

Name of Parent/Guardian: _____ DOB: _____ Social Security # _____
Name of Parent/Guardian: _____ DOB: _____ Social Security # _____
Mailing Address: _____
Street Address (if different than above) _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible and agree to pay any and all charges that are not paid by insurance or any third party payer. I authorize payment directly to Rose Pediatrics for all benefits otherwise payable to me. I understand that if I do not provide all of the requested/necessary information, I will be billed directly for all charges until such information is provided. I also authorize the release of any medical information necessary to process all claims. Failure to comply with this financial policy may result in the following actions: temporary and/or permanent suspension from the practice and referral to a collection agency. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. A Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

X Signature: _____ Date: _____

Print Name: _____

APPOINTMENT GUIDELINES

- **_____(initial) Well-Child appointments are generally scheduled in advance. You may need to schedule your appointment several weeks in advance if you prefer a specific provider, date, or time. Sick visits are available on a daily basis and we encourage you to schedule your appointment on the day your child develops symptoms.**

- **_____(initial) Please arrive at least 10 minutes prior to your appointment time to verify and update your personal information.**

- **_____(initial) In fairness to all our families, patients that arrive more than 15 minutes late may have to reschedule their visit. Schedule permitting, we may still be able to see your child; however, patients on time for their appointment will be given priority.**

INSURANCE INFORMATION

- **_____(initial) As a courtesy to our families, we are pleased to file insurance claims on your behalf. Prior to your appointment time, we will verify that you have active coverage. If your insurance comes back inactive, or we are not able to verify active coverage, you have the option to self-pay or reschedule your visit.**

- **_____(initial) Active coverage does not guarantee payment. Most plans have limitations and exclusions, and coverage varies greatly from plan to plan. Your policy is a contract between your insurance carrier and you; financial responsibility ultimately remains with the family.**

- **_____(initial) Some insurance plans do not cover vaccines, and costs can be very high. Please call your insurance company and verify that your plan covers vaccines. You will be responsible for charges not covered.**

- **_____(initial) Many insurance plans require a designated Primary Care Provider (PCP), for each member of the family. Please select Rose Pediatrics or your carrier may deny your claims.**

- **_____(initial) Some insurance plans have limited or restricted provider networks. Please verify that Rose Pediatrics is "In Network" for your specific insurance plan.**

- **_____(initial) Copays are due at check-in.**

CANCELLATION POLICIES

- **_____(initial) We have a <u>24 hour</u> cancellation policy for Well-Child Visits and ADD/ADHD appointments.**

- **_____(initial) We have a <u>1 hour</u> cancellation policy for all other types of visits.**

- **_____(initial) We have a $25.00 missed appointment fee for all appointments cancelled without appropriate notification as specified above. If you feel your circumstances do not warrant a missed appointment fee, you may submit a waiver request in writing. Once received, we will review your request and a decision will be made on a case by case basis.**

- **_____(initial) Please note that we may discharge your family after three missed appointments without appropriate notification. Over the years we have seen a significant increase in the number of missed appointments, no-show appointments, and appointments cancelled without appropriate notification. This decreases appointment options for everyone. We appreciate your cooperation.**

HIPAA CONSENT

I have been advised that a copy of Rose Pediatrics' Patient Privacy Policy is on display at the front desk, and I understand that I may request a copy of this policy at any time. I also understand that if I have any questions about HIPAA or my child's privacy, I may contact Rose Pediatrics to discuss my concerns. I have received, viewed, or been offered a copy of these policies as required by HIPAA.

X Signature:_____ Date:_____

PATIENT CONTACT PREFERENCES

PRIMARY PHONE NUMBER:_____ (We will send appointment reminders to this number)

SECONDARY PHONE NUMBER: _____

On occasion we may find it necessary to leave a message regarding lab results or other types of personal health information. Please review the "message types" below, and choose an option for each number. Please note that the default message type is "Extended" if not otherwise specified.

BRIEF MESSAGE: We will leave a message with our practice name and a call back number.

EXTENDED MESSAGE: We will leave a message with our practice name and a call back number. In addition we may leave a detailed message regarding lab results or other health information. The contents of these messages will vary.

PRIMARY NUMBER (Pick a Message Type) ☐ Brief Message OR ☐ Extended Message

SECONDARY NUMBER (Pick a Message Type) ☐ Brief Message OR ☐ Extended Message

I authorize Rose Pediatrics to contact me following the patient contact preferences specified above. I understand that my preferences may be changed at any time.

X Signature:_____ Date:_____