Office & Financial Policy

Pediatric Associates is committed to providing your child with the best possible medical care, and a clear understanding of our financial policy is important to our relationship. Our physicians are contracted with most insurance plans; however, we recommend you verify our participation with your plan. Your insurance policy is a contract between you and your insurance carrier. Thus, it is your responsibility to understand and know the provisions of payment for services rendered at Pediatric Associates.

Pediatric Associates follows all billing rules as established by the National Association of Insurance Commissioners, State and Federal Guidelines.

The First 30 Days of Life

Most insurance companies provide automatic coverage for some, or all the first 30 days of life; *even* though the parent may choose not to enroll the baby for continuing coverage. It is mandatory parents provide their information, regardless of whether they plan to enroll the baby of coverage. We allow 30 days for you to enroll your newborn to your insurance plan(s). If at 30 days we are unable to verify coverage through the insurances you provide, the balance becomes your responsibility to pay in full prior to your babies 2-month appointment.

The Birthday Rule

The birthday rule applies to children covered under both of their parent's health insurance plans. An industry standard, almost all health insurers follow the birthday rule to determine which insurance is primary. The rule says that the parent with the earliest birthday month and day provides the primary insurance coverage. If both are in the same month, then coverage derives from the plan carried by the parent born earlier in the month. If both are on the same month and day, coverage comes from the parent who has been covered for a longer period.

Court documents, such as in a divorce can supersede the Birthday Rule, however those documents must be provided to Pediatric Associates and your insurance company; a copy will be kept in the patient(s) file.

Coordination of Benefits

It is the responsibility of the parents to notify their insurances of other existing or termed policies. Not updating the Coordination of Benefits with your insurance companies could result in the delay of payment or non-payment, leaving the responsibility of payment to the parents.

Proof of Insurance

___A copy of your insurance card is required at every visit. Without current insurance information your appointment will be cancelled and/or you will be financially responsible for the entire visit at the time services are rendered. You are required to sign a waiver stating you will be responsible for payment and the billing of your insurance.

___It is your responsibility to keep us updated with correct insurance information. If you provide incorrect insurance information, you will be responsible for a $25.00 reprocessing fee.

___Co-payments are due at the time of service. A $25.00 service fee will be charged if not paid by end of day.

___Secondary Insurance is billed as a courtesy *ONLY,* balances greater than 30 days are your responsibility and due in full immediately.

Patients 18 and Older

___Patients 18 years of age and above will be made financially responsible for services rendered at Pediatric Associates, even though a parent may carry insurance coverage. Laws (PHI) prohibit us from discussing medical and billing information with the parent, unless the patient gives written permission by completing the required forms.

Cancellation/No Show Fee

___We require 24 hours' notice to reschedule or cancel any appointment. Failure to provide at least 24 hours' notice will result in a $35.00 no-show fee. Three or more no show appointments within a family may result in the dismissal from the practice.

Non-Sufficient Funds

___A charge of $35.00 will be added to your account if your check is returned for non-sufficient funds. The balance in due in full within 10 days of returned check.

Divorced or Separated Parents

___The physicians focus is the care and well-being of your child(ren). We will not mediate between personal issues or financial disputes. A copy of court rulings specific to payment of medical bills will need to be kept on file.

Balance Due and Collections

___Statements are sent within 10 days of receiving an insurance payment/denial. Payment is expected upon receipt of said statement. Balances exceeding 90 days from date of service will be turned over to a

collection agency. An additional fee of $75.00 will be added to the account balance. In the event your account is assigned to a collection agency, your family will be dismissed from the practice.

Zero Tolerance Policy

___Pediatric Associates has a zero-tolerance policy when it comes to patients causing disruptive behavior. We do not tolerate abusive language, mistreatment of staff, profanity, threats of social media retaliation, and/or any threats of violence of any kind at Pediatric Associates. If a patient exhibits any type of inappropriate behavior, they will be asked to leave immediately and will be dismissed from our practice.

Pediatric Associates reserves the right to discontinue any services with patients who behave as aforementioned.

Please understand that, if you do have a concern or a problem regarding our office, we want to hear about it; but in a safe, constructive manner. We welcome suggestions for us to provide the best care possible, while also providing a safe environment for our patients and staff.

___I have read and understand the policies of Pediatric Associates.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. Either I or my insurance company may revoke this authorization at any time in writing.

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my child. I understand that this medical information will only be used for the following purpose: diagnostic, referring physician(s) or insurance.

Patient Name_____

Responsible Party Signature_____Date_____

Relationship to Patient_____

PATIENT INFORMATION
FIRST 30 DAYS OF COVERAGE

PLEASE PRINT LEGIBLY

PATIENT NAME:_____
(LAST) (FIRST) (MIDDLE INITIAL)

DATE OF BIRTH:_____/_____/_____ SEX: MALE FEMALE

ADDRRESS:_____
(CITY) (STATE) (ZIP CODE)

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

MOTHERS INFORMATION (A COPY OF YOUR INSURANCE CARD IS REQUIRED)
Even if you are not adding baby to your policy we do require your insurance information to confirm any automatic newborn coverage. PLEASE NOTE: WE WILL NOT ACCEPT INSURANCE COVERAGE FROM A GRANDPARENT WITHOUT A LETTER FROM THE INSURANCE COMPANY STATING THEY ARE AWARE THE NEWBORN IS A GRANDCHILD AND THE POLICY DOES COVER GRANDCHILDREN.

NAME:_____
(LAST) (FIRST) (MIDDLE INITIAL)

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #: _____

BEST PHONE # TO CONTACT YOU: (_____)_____ PRIMARY LANGUAGE_____

EMAIL ADDRESS:_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

Were you employed at the time of the baby's birth? YES NO

If yes, do you have insurance through your employer? YES NO

Will you be providing insurance for you newborn? YES NO

If yes, does your insurance offer automatic newborn coverage? YES NO If yes, for what length of time? _____

EMPLOYER: _____

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBERS NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)

IDENTIFICATION #: _____

GROUP #: _____

(TURN OVER)

FATHERS INFORMATION (A COPY OF YOUR INSURANCE CARDS IS REQUIRED)

Even if you are not adding baby to your policy we do require your insurance information to confirm any automatic newborn coverage. PLEASE NOTE: WE WILL NOT ACCEPT INSURANCE COVERAGE FROM A GRANDPARENT WITHOUT A LETTER FROM THE INSURANCE COMPANY STATING THEY ARE AWARE THE NEWBORN IS A GRANDCHILD AND THE POLICY DOES COVER GRANDCHILDREN.

NAME:_____
(LAST) (FIRST) (MIDDLE INITIAL)

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #: _____

BEST PHONE # TO CONTACT YOU: (_____)_____PRIMARY LANGUAGE_____

EMAIL ADDRESS:_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

Were you employed at the time of the baby's birth? YES NO

If yes, do you have insurance through your employer? YES NO

Will you be providing insurance coverage for your newborn? YES NO

Does your insurance policy offer automatic newborn coverage? YES NO If yes, for what length of time? _____

EMPLOYER: _____

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBERS NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)

IDENTIFICATION #: _____

GROUP #: _____

I attest all the information provided to be true and accurate. I understand that if I provided inaccurate billing information, I will be charged a fee of $25.00 to resubmit the claim.
I hereby assign all rights, title and interest of my primary and secondary insurance to Pediatric Associates for the treatment of today's medical services. I recognize and accept responsibility for any balances and acknowledge outstanding balances are due immediately upon receipt of a statement.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO CHILD: _____

PEDIATRIC ASSOCIATES

PEDIATRIC PATIENT MEDICAL HISTORY

PATIENT _____
D.O.B. _____ AGE _____
DATE _____

	NAME	D.O.B.	LIVE WITH PATIENT?
Mother			■ Yes ☐ No
Father			■ Yes ☐ No
Sibling			■ Yes ☐ No
Sibling			■ Yes ☐ No
Sibling			■ Yes ☐ No
Sibling			■ Yes ☐ No

CONDITION	YES/NO	RELATION
Birth Defects	☐ Yes ■ No	
Hearing/Vision Loss	☐ Yes ■ No	
Juvenile Diabetes	☐ Yes ■ No	
Anemia/Bleeding Problems	☐ Yes ■ No	
Childhood Cancer	☐ Yes ■ No	
Seizure Disorders	☐ Yes ■ No	
Migraines	☐ Yes ■ No	
DD/LD/ADD/MR/CP	☐ Yes ■ No	
Early Onset bp/cvs prob	☐ Yes ■ No	
Lung/Allergies/Asthma	☐ Yes ■ No	
GI	☐ Yes ■ No	
Kidney/GU	☐ Yes ■ No	
Muscle/Nerve/Bones/Joints	☐ Yes ■ No	
JRA/Lupus	☐ Yes ■ No	
Psychiatric Illness	☐ Yes ■ No	
ETOH/Drug/Tobacco	☐ Yes ■ No	
Endocrine	☐ Yes ■ No	
AIDS/ARC	☐ Yes ■ No	

BIRTH HISTORY

BW: Term: Apgars:

Delivery

Problems

DEVELOPMENTAL HISTORY

Gross:

Fine:

Social/Cognitive:

Language:

HOSPITALIZATIONS

PAST ILLNESSES

SURGICAL PROCEDURES

WELL-CHILD SERVICES POLICY

Pediatric Associates

Good health care for newborns, infants, children and adolescents includes regular well-child visits (checkups). Checkups focus on *preventative* services. Our office provides these services based on an initiative called Bright Futures developed by the American Academy of Pediatrics (AAP) with support from the U.S. Health Resources and Services Administration. Bright Futures includes recommendations for preventive pediatric health care for children from birth to 21 years of age, such as physical examinations, screenings, assessments, and advice about health and safety. We also follow the AAP vaccination schedule for newborns, infants, children and adolescents.

The Patient Protection and Affordable Care Act (ACA) requires most health plans to cover *specific preventive services* without cost sharing (i.e., pay in full), including all preventive care services recommended by Bright Futures and immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.[1] This is not always true, though, as *grandfathered plans do not have to pay in full for preventive services*.

There may also be times when a child needs a service that is not part of a checkup on the same day as a well-child visit. If a child is not well or a problem is found during the checkup that needs to be addressed, the doctor may need to provide an additional office visit service (such as a sick visit). This is a different service and is billed to your health plan in addition to the checkup. *If services are provided that are not part of the Bright Future's preventive care recommendations, your health plan may not pay for it in full*. If your health plan requires a co-payment, coinsurance, or a deductible for these non-checkup services, our office will charge you these amounts.

Some services that may be provided and billed in addition to preventative services include:

- The doctor's work to address more than a minor problem, which will be billed as an office visit (e.g., if the doctor gives a prescription, orders or performs tests that are not included in Bright Futures, or changes care for a known health problem)
- Medical treatments (e.g., breathing treatments)
- Any surgery (e.g., removing splinters or something the child put in his nose or ear)

We value your time and want to make the most of each appointment. This is why we try to address any problem that needs a doctor's care during well-child visits so that only one trip is needed. However, in some cases, such as when the additional service is not urgent and will interfere with other patients' appointments, you may have to schedule another appointment.

We do not want you to be surprised by a bill. We bill your health plan and you based on actual services provided. Please feel free to ask about services that may not be paid in full by your health plan on the day of your visit.

Many insurance companies have information on their websites explaining which preventive services are paid in full and conditions or restrictions that may apply to specific plans. Additionally, the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services have websites which you may find helpful in understanding your preventive care benefits:

- HHS.gov/HealthCare Preventive Care
- HHS.gov/HealthCare Preventive Care for Children
- HealthCare.gov Preventive Health Services for Children

SIGNATURE _____ DATE _____

Lpw 3/2017

NOTICE OF PRIVACY POLICIES AND PRACTICES
PEDIATRIC ASSOCIATES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION:

At **Pediatric Associates**, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time your visit **Pediatric Associates** a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to who your protected health information has been disclosed

- The right to restrict disclosures of your protected health information to a health plan where you have paid out of pocket in full for medical treatment received
- The right of affected individuals to be notified following a breach of unsecured protected health information
- The right to opt out of receiving communication regarding fundraising communications
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

Pediatric Associates is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/or locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

We will not use or disclose your health information without your authorization, Disclosure of psychotherapy notes, uses and disclosures of (PHI) for marketing purposes, and disclosures that constitute a sale of (PHI), and other uses and disclosures not described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of **Pediatric Associates.** For example: Information on the services you receive d may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some

examples of these "business associates" might be a billing service, collection agency, and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training. We may use your information for the purpose of research, teaching, and training.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders consist of a brief non-specific message left on your answering machine. If you don't approve of these methods, or if you prefer alternative methods (i.e., e-mail) please inform the practice.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of **Pediatric Associates** please contact:

Directors
Pediatric Associates
645 N Arlington Avenue, Suite 620
Reno, NV 89503
(775) 329-2525

If you believe that your privacy rights have been violated, please contact Pediatric Associates, or, you may file a complaint with the Office for Civil Rights, U>S> Department of Health and Human Services (www.os.dhhs.gov). There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED THE Notice of Privacy Practices of Pediatric Associates.

_____

Signature of Parent or Guardian **Date**

_____

Printed Name **Child's Name**

FOR SSI USE ONLY

Reason acknowledgement was not obtained:

_____

_____

_____

Employee completing this form **Date**