2023 ANNUAL CONSENT FORM

Appt:____/____/2023 @ ___:_____am/pm

w/Dr._______

LEGAL Patient Name:____ **DOB:**______/______/__________

(First Name, Last Name)

Mother's Name:_____________________________ **Father's Name:**______________________________

(First Name, Last Name) *(First Name, Last Name)*

Child resides with: __**Mother & Father** __**Mother ONLY** ___**Father ONLY** __**Mother & Step Father**
__**Father & Step Mother** __**Other**__________________________

CONSENT TO TREAT:

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my child's health and wellbeing. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

RELEASE OF PROTECTED HEALTH CARE INFORMATION:

I give my consent and authorization for the staff of Pediatric Associates, Inc. to leave protected Health Care Information about my child on my answering machine or voice mail via the telephone number(s) I have listed above. I also give my consent for PAI to receive and respond to my emails that may contain PHI or send out emails that may contain PHI with verbal consent. I understand that I may revoke this privilege at any time by submitting my request in writing to this office.

Payment is required at the time services are rendered unless other arrangements have been made in advance.

This includes applicable coinsurance and co-payments for participating insurance companies. Payment will be expected from whoever brings the child in for the appointment even if they are not the account guarantor. If a divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent or guarantor's responsibility to collect from the other parent. Pediatric Associates, Inc. accepts cash, personal checks, Visa, MasterCard, Discover, and most debit cards. There will be a service charge of **$20.00** on all returned checks. We understand that full payment may not be possible in certain circumstances; if this is the case, please contact our Billing Office. Any payment plan is a binding contract and referred to a "Monthly Payment Agreement". In order for services to be rendered, patients with a payment arrangement must be in full compliance with all conditions of the payment arrangement. Failure to make scheduled payments on the monthly payment agreement or not paying off a balance in full may result in your account being turned over to a collection agency and your family will be dismissed. We will advise you to seek your child's immunizations through a clinic or health department due to your financial situation.

INSURANCE: You will be expected to present your insurance card with each visit.

We bill participating insurance companies as a courtesy to you. It is your responsibility to know your insurance. If the insurance company has not processed or paid a claim within a timely manner, payment of the account may become the responsibility of the guarantor. Your health plan may not be liable for service rendered if any of the following conditions apply: My child/children may have a preexisting condition or other diagnosis that may not be covered by my plan. Provider not participating in my health plan-Unmet deductible under my health plan contract-Services may not be covered under my health plan-Well child checkup, immunizations, as well as other routine services may not be covered by some insurance plans. If you feel that your insurance company unfairly denies your claim, it is your responsibility as parent/guardian to pursue the insurance company on your child's behalf. If you need assistance or have questions, you may contact our billing office @ 260-250-4250 Monday – Friday between the hours of 8am-4pm.

REFUNDS: Overpayment will be refunded upon request to the responsible party within 30 days.

NO SHOW/MISSED APPOINTMENT FEE:

Our office requires a 24hour PRIOR notice of any cancellations. Failure to comply may result in a **$25.00 fee** applied to your account. P.A.I. reserves the right to dismiss my family after **3** missed appointments.

COLLECTIONS:

Referral to our professional collection service will be made on delinquent accounts when payment and/or payment arrangements have not been made. If your account is referred to a collection agency, you agree to pay all collection costs that are incurred. This could also result in dismissal from our practice. Should your family be dismissed from the practice, you will receive written notification and given adequate time to find a new medical provider. If your account is submitted to a collection agency, the fact that you received treatment at our office may become a matter of public record.

Once you have signed this agreement, you agree to all the terms and conditions contained herein, and the agreement will be in full force and effect. I have read and understand the Financial Policy of Pediatric Associates, Inc. and that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian. I hereby authorize my insurance benefits to be paid directly to the physician unless paid in advance by the patient, and I am responsible for non-covered services. I hereby verify that the billing, insurance and patient information is accurate and current. I also authorize the physician to release any information required to process this claim and agree that a photocopy of this authorization is as valid as the original.

I, ___________________________________, have reviewed the information above and verified its accuracy or made any needed changes.

X____ _______/______/**2023**

(Signature of biological parent, legal guardian or patient) *(Date)*

Acknowledgment of receipt of notice of privacy practices (Federal HIPAA Privacy Regulations)

By my signature below I am acknowledging that the office of PAI has provided me with a copy of their Notice of Privacy Practices.

Pre-Authorized Healthcare Form (This section is OPTIONAL)

I authorize Pediatric Associates Inc. to keep my signature on file ***and*** to charge my credit card for **any balance due.**

I assign my insurance benefits to the provider listed above. I understand that this form is valid UNTIL I cancel the authorization through written notice to Pediatric Associates Inc.

O DISCOVER O MASTERCARD O VISA

______________________________ ______________________________ MO:_______ YR:________ 3Digit:________

(Account Number) *(Cardholder Name)* *(Expiration)*

____

(Cardholder Billing Address)

X____ ______/_____/**2023**

(Signature) *(Date)*

Referral to OUT OF NETWORK PROVIDERS Notice

1. An out of network provider may be called to render healthcare items or services to your child(ren) during their course of treatment.
2. An out of network provider is not bound by payment provisions or terms that apply to healthcare items or services rendered by a network provider under your health plan.
3. You may contact your health plan before receiving healthcare items or services, or you may contact your health plan for additional assistance.
4. This notice is being provided to you in accordance with Indiana law. It is to notify you that healthcare items or services your child(ren) receive, from a provider that are out of network may cost you more than a provider who is part of your insurance or health plan's network of providers. If your physician refers you to a provider, contact the customer service of your health plan or insurance company to determine your financial liability for services by an out of network provider and see if there is a network provider that may available to provide you the healthcare items or services at a lower cost.

HIPAA AUTHORIZATION AND CONSENT to TREAT

****OTHER THAN PARENT, LEGAL GUARDIAN or PATIENT****

I give my consent for the person(s) listed below to have the right and privilege to request service, medical records or treatment for my child(ren) should I not be present or available via telephone or otherwise.

Name ***(**Other than Parent, Legal Guardian, or Patient)***	Relationship to patient	Phone#
______________________________	______________________	(_____) _____-_________

Name ***(**Other than Parent, Legal Guardian, or Patient)***	Relationship to patient	Phone#
______________________________	______________________	(_____) _____-_________

This consent/authorization is valid for all of my children listed below:

1) ________________________ **DOB:**____/____/______ **2)** ________________________ **DOB:**____/____/______

3) ________________________ **DOB:**____/____/______ **4)** ________________________ **DOB:**____/____/______

5) ________________________ **DOB:**____/____/______ **6)** ________________________ **DOB:**____/____/______

7) ________________________ **DOB:**____/____/______ **8)** ________________________ **DOB:**____/____/______

I,________________________________, understand by signing this form that it is my responsibility to inform P.A.I. of any changes to my account (i.e. address, phone, insurance etc.) or to the information above. This form will expire 1 year from today's date at which time a new form will be required. (Unless otherwise requested)

X____ ______/______/**2023**

(Signature of biological parent, legal guardian or patient) *(Date)*