22709 S Ellsworth Rd. Ste. F104, Queen Creek, AZ 85142

OUR OFFICE POLICIES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW TO ACKNOWLEDGE YOUR UNDERSTANDING OF THE PROVIDED INFORMATION

1. **INSURANCE**: We participate in most insurance plans, including AHCCCS. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured with a plan we do business with but do not have an up-to-date insurance identification card, payment in full is required for each visit until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. **CO-PAYMENTS & DEDUCTIBLES**: ALL co-payments and deductibles must be paid at the time of service. Our office **WILL NOT** bill for any co-payments. Your payment is an arrangement which is part of your contract with your insurance company. We are not a party to that contract. Failure on our part to collect co-payments/deductibles can be considered fraudulent. Please help us in upholding the law by paying your co-payment/deductible at the time of visit.
**In cases where deductible or co-insurance amount remain undisclosed until we receive your child's claim and invoice for their visit, Pediatrics of Queen Creek will then mail you a letter in which your patient balance due will be included. The balance of your child's account is expected to have been fully paid within 30-days from the date postmarked on your letter.

3. **NON-COVERED SERVICES**: Please be aware that some-and perhaps all-of the services you receive may not be covered or considered reasonable or necessary by AHCCCS or other insurance plans. If a claim has been denied by your insurance company for those reasons you will be responsible for full payment for these services.

4. **PROOF OF INSURANCE**: All patients MUST complete our patient information form before seeing the doctor. We must obtain a current valid insurance card in order to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **CLAIMS SUBMISSION**: We submit your claims and assist in a reasonable way to ensure the payment of your child's visit. By signing below, you authorize PEDIATRICS OF QUEEN CREEK to submit your medical claims from visits at our office on the patient's behalf. I authorize release of my PROTECTED HEALTH INFORMATION required by insurance carriers for purposes of submitting claims and collecting payment. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees. Your insurance company may require you to supply certain information directly. It is your responsibility to comply with their request. Please be aware the balance of your claim is your responsibility whether or not your insurance company pays your child's claim. Your insurance benefits are a contract between you and your insurance company; **we are not a party to that contract**.

6. **PRIVACY ACT**: I am aware of the **Notice of Privacy Practices** which has been given to me or posted with the office for my review. I further understand that I can request that my **Protected Health Information** be limited by requesting so in writing to the Privacy Office. I understand that this authorization meets the needs of HIPPA (Health Insurance Portability and Accountability Act) guidelines set forth by the Federal government in regard to patient confidentiality. "I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider."

7. **COVERAGE CHANGES**: If your insurance changes, please notify us PRIOR to your child's next visit to assure that the appropriate changes will be made in order for you to receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **NON-PAYMENT**: If your account is over 60-days past-due, you will receive a letter stating that you have 15 days to pay your account in full, including a $25.00 late payment fee. Partial payments will no longer be accepted. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and you and your immediate family may be discharged from our practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. **MISSED / NO-SHOW APPOINTMENTS**: Our policy is to charge a fee of $25.00 for any/all missed appointment not cancelled within a reasonable amount of time. **(Our practice REQUIRES a 24-hour cancellation notice prior to your child's scheduled appointment – unless an emergency.)** These charges will be your responsibility and will be billed directly to you. For all patients, including those under AHCCCS insurance plans, your child will immediately be removed from our patient roster after 3 subsequent missed appointments –in which you will have 30 days to find alternative medical care.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank-you for understanding our patient payment policies. Please inform us if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THE PATIENT POLICIES AND AGREE TO ABIDE BY ITS GUIDELINES:

______________________________ SIGNATURE OF PARENT/GUARDIAN/RESPONSIBLE PARTY

______________________________ DATE

______________________________ PATIENT'S NAME (please print)

______________________________ PATIENT'S DATE OF BIRTH

_____ Please check here if you consent to voice messages regarding patient test results (Ex: "We are calling to inform you that your recent lab results came back negative.")

. Check one: _____YES (Ok to leave voice messages) **_____NO (DO NOT leave voice messages)**

_____YES (Ok to communicate through the portal using email) **_____NO (DO NOT communicate through the portal using email)**

_____YES (Ok to text me about appointments/billing) **_____NO (DO NOT text)**

_____YES (Ok to call my cellular phone) **_____NO (DO NOT call my cellular phone)**

CONSENT FOR TREATMENT

I______________________________, give permission to PEDIATRICS OF QUEEN CREEK to care for and treat my child. I
(name of parent/guardian/responsible party)
understand that my child cannot be treated without my presence unless I've given written consent to an adult **OVER THE AGE OF 18** to seek such care or treatment.

In my absence the following adults OVER THE AGE OF 18 may seek medical attention for my minor child:

Name:______________________________ Relationship to child:______________________________

Name:______________________________ Relationship to child:______________________________