BRENTWOOD PEDIATRIC CARE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Brentwood Pediatric Care may use and disclose protected health information ("PHI") about me or my child/children to carry out treatment, payment and healthcare operations ("TPO"). Please refer to Brentwood Pediatric Care Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Brentwood Pediatric Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Brentwood Pediatric Care.

With my consent, Brentwood Pediatric Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my or my child's/children's clinical care, including laboratory results among others.

With my consent, Brentwood Pediatric Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Brentwood Pediatric Care may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Brentwood Pediatric Care restrict how it uses or discloses my or my child's PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Brentwood Pediatric Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Brentwood Pediatric Care may decline to provide treatment to me or my child/children.

Signature_____ Relationship to Patient: _____

Print Name: _____ Date: _____

Child's Name(s):_____ _____

_____ _____

_____ _____

FINANCIAL & OFFICE POLICY

Thank you for choosing Brentwood Pediatric Care as your Pediatric provider. It is our hope that our patients understand our office policies are a necessary part of assuring the financial resources required to maintain vital health care for our patients and the community. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office and financial policies allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments:

- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- All children under the age of 18 must be accompanied by an adult for well visits, ADHD, chronic illnesses, lab follow-ups, and allergy testing. Children 16 and older maybe unaccompanied for sick visits with a signed authorization from the responsible party.

Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you come prepared to present your insurance card at every visit to verify that our office has the most updated card on file.
- All newborns are considered self pay until we can verify insurance. If your newborn is covered by insurance, please contact us with the name of the plan, the subscriber name, and ID number. Most insurance plans give you 15 -30 days to add newborns to family plans.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- It is your responsibility to understand your benefit plan. Well Appointments - According to children's age there are surveys that will be required for you or your child to complete. They are a necessary part of the visit and are standard of care. The survey must be billed and charged under individual billing code separate from the well visit code. If these services are not covered, you will be responsible for payment.
- Not all plans cover well child visits, vision/hearing screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment..

Financial Responsibility:

- We do not get involved with domestic disputes and custody issues. Our policy is to obtain payment at the time of service from the parent/guardian bringing the child to the office. The person who the patient resides with is responsible for any balances due upon receipt of a statement.
- According to your insurance plan, you are responsible for all co-pays, deductibles, and coinsurances.
- Co-pays are due at the time of service.
- Self-pay patients are expected to pay for services in full at the time of visit. This includes patients that we do not participate in their insurance plan. Our office will be happy to furnish a print out with all the necessary codes for you to file the claim for reimbursement with your insurance company for which we do not participate.
- We accept cash, check, and all major credit cards.
- Brentwood Pediatric Care reserves the right to change fees without notice.
- Any families asked to transfer care for non-compliance of our policies will not be accepted back into our practice.
- No charge for medical records sent via fax to another physician's office

I have read and understand this Financial and Office policy and agree to comply and accept the responsibility for any payment that becomes

Responsible Party's Name:_____Relationship:_____

Responsible Party's Signature:_____Date:_____