POLICIES OF PREFERRED PEDIATRICS

HEALTH INSURANCE

As a courtesy to me, Preferred Pediatrics will file claims for healthcare services provided on my behalf directly to my insurance carrier as long as my account remains in good standing. If my child has more than one insurance, it is my responsibility to provide the policy details to Preferred Pediatrics. I hereby assign directly to the physicians, any and all health insurance benefits to which I am entitled and which are payable to me for any services rendered. If my insurance does not release payment to Preferred Pediatrics due to lack of coordination of benefits, I understand that I will be financially responsible for any and all unpaid charges. I also understand that any unresolved insurance matter can lead to dismissal from the practice.

NO INSURANCE OR LIMITED COVERAGE

If I have no coverage or limited coverage for the charges incurred on this account, I agree to pay the full balance of such charges at the time of service or in accordance with payment terms agreed upon by Preferred Pediatrics. I am responsible for (1) determining whether the services of Preferred Pediatrics are covered by my insurance contract, (2) verifying that my correct insurance and contact information is on file, and (3) for promptly notifying Preferred Pediatrics of any changes. Well visits, immunizations, and any other charges denied by my insurance carrier are my financial responsibility. I understand that all available courses of action will be utilized by Preferred Pediatrics to secure payment on delinquent accounts, including but not limited to professional collection services and credit bureau reporting. If applicable, professional collection fees and attorney fees will be charged to my account.

RELEASE OF INFORMATION/HIPAA

I understand that Preferred Pediatrics may use and disclose my protected health information for purposes of treatment, payment and health care operations. I authorize Preferred Pediatrics to release any and all medical information, including but not limited to a photocopy of patient's medical records. I also acknowledge that I have received, been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the practice, and individuals involved in my care in the practice, may use and disclose my PHI. As stated in the notice, the terms may change. To obtain a copy of the current notice, please contact the privacy officer at 540.604.9500. I understand I have the right to request that the practice restrict how my PHI is used or disclosed for treatment, payment or health care operations, but I also understand that the practice is not required to agree to a requested restriction. I understand that I have the right to revoke this consent in writing at any time, except for the extent that the practice has already used or disclosed my PHI in reliance on my prior consent.

SCHEDULING

I understand that well-visit appointments must be made in advance. As a practice Preferred Pediatrics follow the guidelines for well-visits suggested by the American Academy of Pediatrics. Preferred Pediatrics recommends a newborn, 2-4 week , 2 month, 4 month, 6 month, 9 month, 12 month, 15 month, 18 month and 24 month well-visit. After these visits it is

recommended that visits be done annually. I understand it is my responsibility to contact my insurance company to verify what well visits are part of my specific benefits. If different from the AAP guidelines, I will discuss with our pediatrician. I agree to arrive 15 minutes earlier than my appointment time and to call if I anticipate being late. I will provide 24 hours advance notice if I need to cancel an appointment. I understand that visits are by appointment only. I understand that a charge will be applied to my account if I fail to appear for a scheduled appointment. These charges are not covered by insurance, and I understand that I will be financially responsible. Charges will be applied accordingly: $10.00 for a missed nurse visit, $25.00 for a missed sick/follow up visit, and $50.00 for a missed well/long visit. As a courtesy, Preferred Pediatrics confirms appointments via an automated voice/text service 1 week and 2 days prior to a scheduled appointment. I understand that Preferred Pediatrics reserves the right to dismiss patients from the practice after three missed appointments in a 12-month period.

NSF CHARGE

I agree to pay a $60.00 charge on all checks returned for "Non-Sufficient Funds."

I have read and understand the above policies. I agree that such policies may be changed from time to time at the discretion of Preferred Pediatrics and I will comply to any such changes for as long as I have an account here. My signature acknowledges my full responsibility for any charges to this account regardless of my marital status, custody arrangements, or whether or not I am the legal guardian for the minor patient named below. My signature implies my authority to seek medical care for this patient, and I expressly give the physicians and staff of Preferred Pediatrics permission to provide medical treatment any time the patient is presented for such and this account may be charged accordingly.

Patient Name _____ *Patient DOB* _____

Name of Responsible Party _____

Signature of Responsible Party _____

Date _____

Preferred Pediatrics Employee _____

Date _____