The Center for Advanced Pediatrics (TCFAP), URGI-Kids, and All Specialty Services Financial, Privacy, Vaccine, and Treatment Policies & Procedures Consent Agreement

Please initial each section acknowledgment and sign at the bottom of the form

Working with my Insurance

I authorize TCFAP to submit each visit and service to my insurance company on my behalf. I authorize the release of any medical or other information for the purpose of providing care or securing payment for services rendered. I authorize the payment of medical benefits directly to TCFAP.

I agree that I am financially responsible for any charges not covered by my insurance carrier for services provided by TCFAP including but not limited to: co-insurance, copayment and/or deductibles and agree that I am to pay any of these non-covered charges at the time of service.

I understand and agree that if my insurance company subsequently notifies TCFAP a rendered service is not a covered benefit for any reason on my insurance plan, I am to pay in full the amount not covered upon receipt of the patient statement ("EOB") and my credit card will be charged.

During well visits if any ADDITIONAL concerns or conditions arise, these will have additional codes and charges and therefore may require a CO-PAY at your child's well visit. Some insurance companies have changed how they process preventative services. I understand it is my responsibility to check with my insurance company for well visit coverage.

Working with my Insurance Initial _____

Credit Card Policy

I understand that TCFAP requires a credit card on file. My insurance requires payment at time of service for all deductibles, co-pays, and coinsurance. As a courtesy, TCFAP will keep my credit card on file and process payment when the EOB is received from my insurance. Otherwise all charges must be settled at the time of service. NO EXCEPTIONS to this policy. ***I understand it is my responsibility to checkout at the time of visit if I refuse to leave my credit card on file***. If I do not settle at check-out and do not have a credit card on file, my account will be considered past due and a $25 fee will be incurred.

I understand it is my responsibility to update my credit card on file when it expires or is replaced. I understand that having a credit card on file ensures payment and allows me additional time to settle my account and that credit cards are stored electronically and are encrypted. State and federally funded insured are not required to leave a credit card on file as there is no balance billing.

I understand that if I am a non-TCFAP patient/visitor or using one of TCFAP additional services beyond primary care (Behavior Health, Lactation Services, Travel Medicine, Nutrition and/or any future services that might be offered) I am required to place my credit card on file. As above, state and federally funded insured are not required to leave a credit card on file as there is no balance billing. **Credit Card Policy Initial**_____

Office Hours

Business hours at TCFAP & URGI-Kids are M-F 9 am-5 pm. Services rendered outside of these times are considered after hours and CPT codes 99050 and 99051 apply. If my insurance does not cover these, I am responsible.

Office Hours Policy Initial_____

Administrative Fee

I agree that the annual administrative charge includes unlimited form completion, medical letters of necessity, non-medical insurance forms such as FMLA, disability, life and other administrative services. I will incur an annual charge of $40 for children ≤ 18 years old and $20 for young adults ≥ 19 years old and will be charged annually to my credit card. This is the responsibility of parent/guardian and cannot be submitted to any insurance carrier. This fee is waived for state or federally funded insured and visiting patient families.

Admin Fee Policy Initial_____

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Cancellations

I understand and agree that fees will be assessed for missed appointments and late cancellations. The fees are $75 for sick visits (24 hr cancellation), $100 for physicals (48 hr cancellation), and $175 for specialty appointments (72 hr cancellation). Per state requirements, this fee is waived for state or federally funded insured.

I understand that if my account is over 30 days past due, the process of being sent to collection will be initiated. Should the account be referred to a collection agency, I will pay all reasonable fees and collection expenses, and I understand that all delinquent accounts bear interest at the legal rate. I will be able to receive emergency care for my children for 30 days but will not be able to schedule appointments until my account is settled.

Cancellations Policy Initial_____

Medical Records

I understand that my administrative fee allows me to receive a copy of my medical records on disc. All other paper copies will be charged at the state rate per page. Records for non-emergent needs can take up to 30 days. As per State rules, state and federally funded insured are not charged for medical records.

Medical Records Policy Initial _____

Acknowledgement of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that TCFAP works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that TCFAP may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

TCFAP has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods or to an alternative location. This Notice of Privacy Practices may be updated periodically.

Initial Privacy Practices_____

Acknowledgement of Vaccine Administration Policy

I understand that TCFAP will administer vaccines in accordance to the American Academy of Pediatrics Guidelines. I also understand that I will be given information about these vaccines and the opportunity to discuss them prior to administration. TCFAP does not accept families who do not vaccinate or under vaccinate their children or follow alternative schedules.

Initial for Vaccine Policy _____

Permission to Treat

I understand that by signing below I authorize TCFAP to provide medical care reasonable by today's standards.

Initial for Permission to Treat _____

Acknowledgement of Financial Consent, Privacy and Vaccine Policy, and Permission to Treat

Signature of Parent/Guardian: _____ **Date** _____

NAME of Parent/Guardian: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

For expanded information about our office practices and policies, please visit www.tcfap.com