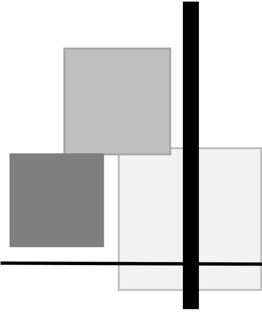

Premier Pediatrics, P.A.
8675 College Boulevard, Suite 100
Overland Park, KS 66210
913-345-9400 - Office
913-345-9408 - Fax

Financial & Office Policies

Initial ____ **Authorization to Treat**: I authorize the physicians/providers of Premier Pediatrics to render any necessary treatment to my child. Premier Pediatrics is providing care under the assumption that the person bringing the child to the office has been authorized by parent/guardian to bring the patient in for care, therefore authorizing Protected Health Information (PHI) to be shared with the person accompanying the child**.** This will remain in effect from this date forward unless "written" revocation of such.

Initial ____ **Authorization to release information and Assignment of Benefits**: I hereby authorize the physician to release any information acquired in the course of my child's treatment necessary to process insurance claims. ***Authorization to pay benefits to Physician:*** I hereby authorize payment directly to the physician the surgical and/or medical benefits, if any, otherwise payable to me for services rendered, realizing that I am responsible for paying any co-payments, deductibles and other fees not covered by my insurance carrier.

Initial ____ **Insurance Plan:** I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen at "out of network" benefits. Any questions about medical, well baby/preventative care, labs/x-rays and immunization coverage should be directed to my insurance carrier prior to my visits. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Initial ____ **Payments:** I guarantee that I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for the services rendered by the practice providers within 45 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my account in the event that my insurance eventually pays. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will be my responsibility.

Initial ____ **Credit Card on File:** We require all parents to leave a credit card number on file with our office. The card number will not be stored on our computer servers, rather encrypted off site at Instamed's Secure Data Centers. You can be assured your information is secure. The card may be used as a convenient solution to paying your account balance and ***will be used*** for those patient accounts that have been delinquent for more than 90 days. There will be a phone call made to you to notify you of charges being placed on the card.

Initial ____ **Collections:** If I have not paid my bill or have not arranged for a payment plan, the practice may ask for the assistance of an outside collection agency. If my account is turned over to a collection agency, I will be dismissed from the practice. Once an account is placed with a collection agency, a ***25% collection charge*** will be added to cover the collection fees. The practice will try to work with me to avoid being sent to a collection agency.

Initial ____ **Returned Check:** All checks that are Returned Checks/Insufficient Funds will have an additional $35 charge added to the account.

Initial ____ **Check In:** Co pays and past due balances are due at the time of check-in. Please come prepared to pay. Regardless of who brings the child in for patient services, payment is expected. Payment collection will not be delayed for any reason. If you do not have your copay or have not come prepared to pay past due balances, your appointment may be rescheduled for a later time so that you may meet your obligation. Please also bring your current insurance card with you at each visit. For all visits we will ask you to verify insurance and demographic information so that our records remain current.

PLEASE CONTINUE ON REVERSE SIDE

Initial ____ **After-hours Triage Calls:** Premier Pediatrics has a physician on call 24 hours a day/every day. During our "off" hours we use the Children's Mercy Triage service (similar to the triage our nurses provide during office hours). Children's Mercy charges Premier Pediatrics and we split the cost with the family for this service. We also have a Symptoms and Diagnosis link on our website to assist during off hours.

Initial ____ **Office Behavior:** Our mission at Premier is to have a relationship with our families of mutual respect. Should a concern or serious issue arise it is best to contact our Practice Administrator or Nurse Manager. Confrontational behavior toward Premier Pediatric employees whether it is in person or on the phone can be basis for dismissal from the practice.

Initial ____ **Appointments & Late Arrivals:** We ask you to arrive on time to your appointment. If you are more than **15** minutes late you will be rescheduled.

Initial ____ **No Shows:** Patients who do not keep their appointments deprive others of an opportunity to see their doctor. Please call us as soon as you know that you will not be able to keep an appointment. ***We reserve the right to charge a $40 no show fee if the appointment is cancelled less than 24 hours or the patient simply does not show for the appointment. If there are three No Show or same day cancellation occurrences, we reserve the right to let you go from the practice.***

Initial ____ **Forms:** At your request a completed generic health form will be provided at every well visit for each of your children free of charge. This form can be used for all school and camp applications. We will NOT complete a form for patients who have not had a wellness visit in the last 12 months. Forms requested after the well visit will be sent to you through the patient portal free of charge. There is a $10 charge for all other requests of health forms and may take up to 10 days to process. Special processes such as guardianship, social security benefit application, FMLA paperwork, etc. will be done within 14 business days at a cost of $25.

Initial ____ **Notice of Privacy Practices (HIPAA):** I understand the Notice of Privacy Practices documents that are made available to me regarding HIPAA. I understand that I have the right to ask for a complete copy of these documents for evaluation at any time.

Patient Name: ________________________DOB____________ Patient Name: ________________________DOB______________

Patient Name: ________________________DOB____________ Patient Name: ________________________DOB______________

Patient Name: ________________________DOB____________ Patient Name: ________________________DOB______________

(Please list all family members with first and last names seen at Premier Pediatrics)

By signing below, I acknowledge understanding of all of the policies initialed above.

PRINT NAME (first and last): ____

Signature: ____ Date: _____________________

(Signature of parent or legal guardian if patient is less than 18 years old)
(Signature of PATIENT if over 18 years of age)

(This Financial Agreement is Effective for 2 Years from Date Above)