

## Patient Re-Registration Packet and Financial Policy Agreement

Thank you for choosing Healing Hearts Pediatrics P.L.C. for your child's health care. We are committed to providing quality medical care for your children. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior beginning treatment.

### **Insurance**

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to those plans with which we have a contractual agreement. As a courtesy, we will file claims to those plans with which we do not have a contractual agreement as unassigned and the insurance company will send the payment directly to you, therefore full payment is expected at the time of service.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the 1<sup>st</sup> day of the month after the charge has printed on your statement.

Non-covered or allowed services will only be charged to you per the contract Healing Hearts Pediatrics P.L.C. has with your insurance company. Examples of this would include screening exams and/or telephone encounters.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amount as well as approved labs, radiology facilities, and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you.

If you have insurance coverage with a plan with which Healing Hearts Pediatrics does not participate or you currently have no health insurance, charges for your child's care and treatment are due at the time of service, unless prior financial arrangements have been set up by calling the Office Manager at 480-821-1400 extension 204.

### **No Insurance**

If you have no insurance coverage Healing Hearts Pediatrics has implemented a Sliding Fee Scale for those services that are 'Medical Necessary'. Elective services are not eligible for the Sliding Fee Scale and an example of elective services would be a Well child Exam. The Sliding Fee scale is based on the number of persons in the family unit along with the gross income of the parents of the child Exam. The Sliding Fee Scale is based on the number of persons in the family unit along with the gross income of the parents of the child. An 'Application for Uncompensated Services' is available for completion, but must be completed prior to the service.

### **Deductibles/Co pays/Payments**

Our insurance contracts require us to collect deductible amounts and co pays at the time of service. These amounts will be collected prior to service being rendered. For your convenience we accept Visa, MasterCard

and American Express in addition to personnel checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fees assessed to Healing Hearts Pediatrics.

**Appointments**

Our goal is to provide the best possible care and physician availability to each of our patients. Our policy is to request you to call and cancel appointments 24 hours prior to scheduled appointment. Please call us, as early as possible, when you know you will need to reschedule and/or cancel an appointment.

**Minor Patients**

For all services rendered to minor patients, the parent and/or guardian responsible for patient is responsible for payment.

**Information**

I hereby agree that the above enrollment information is correct and I also agree that any changes to the enrollment information will be communicated to Healing Hearts Pediatrics P.L.C. as required to fulfill the medical and financial obligation for services rendered.

**Authorization**

I hereby request and consent that my medical records and non written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by the Healing Hearts Pediatrics P.L.C. and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the above.

I also consent to release of immunization records and medication information to my child’s school and/or pre-school which is deemed pertinent and necessary for my child’s enrollment and/or healthcare in the school district in which my child attends.

**Financial Authorization**

I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any from the insurance carrier to Healing Hearts Pediatrics, P.L.C. If paying cash, I am responsible to pay at the time of service.

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Date



## Acknowledgment of Notice of Privacy Practices and Patient Rights and Responsibilities

I have been presented with a copy of the Notice of Privacy Practices for the office of Healing Hearts Pediatrics, P.L.C. detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Notice of Privacy Practices.

I have been presented with a copy of the Patient Rights and Responsibilities and the Non-Compliance Reporting Form(s) for the office of Healing Hearts Pediatrics, P.L.C. and understand the process for reporting Non-Compliance incidents. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Patient Rights and Responsibilities and reporting forms for Non-Compliance incidents.

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Printed Patient Name

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Signature of Parent or Guardian

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Printed Name of Parent or Guardian

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Date



## Well Child Check Notice

Dear Parent/Guardian:

Your child will probably be scheduled for a Well Child Check with Healing Hearts Pediatrics in the future. As your physicians, we believe that wellness exams are a reasonable and necessary part of your child's healthcare. These exams include a Well-Child Check, Sports Physical and Complete Physical Exam. As part of these exams a screening exam for vision and hearing will be conducted as indicated as a part of the exam and billed in addition to the exam. The diagnosis and procedure codes submitted to your insurance company for today's visit will be wellness codes and hearing and vision screens, if appropriate.

Please be aware that some insurance plans do not cover Wellness Visits or screening procedures. In addition, those plans that do cover Wellness Visits will often cover only one Wellness Visit during a specific interval of time. For example, one Complete Physical every 12 months or a 6-month Well-Child Check on or after the child is actually six months old.

Be advised, some insurance plans do not cover vision and hearing screening. We feel screening vision and hearing are an important part of the care of a growing child. The burden of researching if vision and hearing screens are covered, if any, lies with the policyholder and not with this office. If you have had a vision and hearing screen done elsewhere or do not wish to have these as part of the exam, please communicate this with us at the beginning of visit.

In addition, some insurance plans do not cover any immunizations or cover them only when administered according to a pre-defined schedule. Be advised that the burdens of researching which immunizations are covered, if any, also lies with the policyholder and not with this office.

Should your insurance company deny payment for any portion of today's visit, you will be responsible for the balance that is not paid for by your insurance.

Thank you for your cooperation in this matter.

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Patient Name (Please print)

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Signature of Parent or Guardian

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Printed Name of Parent or Guardian

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Date



I hereby authorize the following individuals to make medical decisions for my child in the event of my absence.

**(Persons other than parents or guardians)**

**\*Parents, please keep in mind, emergencies do come up and unless a person is listed on your child's chart, per HIPAA guidelines, they will NOT be able to have your child treated without documentation from you that they have authorization to have child seen without you being present! Please list ANYONE who may EVER need to bring your child in, in the event that you can not! Persons living outside of state are acceptable! Thank You!**

**Examples:** (Grandparents, Older Siblings, Aunt/Uncles, Child Care Providers)

Name of Person	Relationship to Child

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Effective Date