SOUTH SUMMIT PEDIATRICS

PRIVACY PRACTICES ACKNOWLEDGMENT/HIPPA

By signing this form, you acknowledge that the full Notice of Privacy Practices are available to you by accessing our website, reviewing the Notice of Privacy Practices posted in the clinic, or contacting the clinic via telephone and requesting a copy be sent to you in the mail or requesting a copy at the time of your appointment.

By signing this form, you consent to our use and disclosure of your and/or your child(ren's) protected health information to carry out treatment, payment activities, and healthcare operations. This includes, but is not limited to, submission of insurance claims and consultation with other specialists, laboratories, and diagnostic providers if necessary. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time.

FINANCIAL POLICY AND AGREEMENT

Each patient's parent/parents legal guardian is responsible for the payment of their dependent's treatment and care.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claim processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance carrier pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

Patient's parent(s), legal guardian(s) who have no insurance for their dependent child are required to pay for their visit at the time of service in full. If this is not possible, you will need to make payment arrangements with our office prior to services being rendered. A $20.00 fee will be charged on all returned checks by our office in addition to any charges applied by our check collection agency.

Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.

You are responsible for knowing what your insurance coverage is and what provider network(s) are covered under your health insurance plan. Any service provided by our medical staff, but not covered by your insurance carrier is your responsibility to pay. Be aware that some simple and minor medical services such as, but not limited to impacted ear wax removal, casting sutures, wart removal, skin tag removal, circumcisions, ingrown toenail removal and frenectomy are considered under your surgical benefit by most insurance plans. This may result in charges being applied to your deductible and in some cases will not be covered at all.

You are responsible for any laboratory service performed at this facility that are required to be sent out to an outside third party laboratory for processing. All billings for laboratory services are generated through the lab itself; we do however provide your personal and insurance information to the lab for billing purposes only.

If for any reason, if collection of unpaid bills becomes necessary, the responsible party agrees to pay an additional 38% of the owing balance as a collection fee, and all legal fees of collection with or without suit including attorney fees and court costs.

Please be advised that we may charge a $50.00 fee for no-show appointments. Please be advised that we may charge a $25.00 fee ($80.00 for cancelled therapy/counseling appointments) for appointments cancelled without adequate prior notice, which is defined as before the close of business of the previous business day.

Accounts past 90 days will be charged interest at a rate of 1.5% monthly (18% annually). A late fee of up to $20.00 per month may be charged to past due accounts.

Authorization to Pay Benefits

I further authorize and direct said agency, attorney or insurance carrier to pay from the proceeds of benefits of recovery or insurance payments in my dependant's case, directly to medical providers at South Summit Pediatrics, for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for paying my dependents medical provider in a timely manner.

Patient Name: ______________________________

Signature of Responsible Party: ________________________________ **Date:** ______________