



## **South Lake Pediatrics Consent for Services**

### **Consent to Treat**

I consent to and authorize the physicians, nurses, and other healthcare providers at South Lake Pediatrics to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration for me or my child as deemed medically necessary in their professional judgment. I know that there are some risks with all medical treatments and procedures, and I understand that no one can guarantee how well treatments or procedures will work. I understand that I have the right to be informed of the nature and purpose of all services provided to me or my child at South Lake Pediatrics, as well as alternatives, risks, consequences, or complications of such services.

South Lake Pediatrics is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers. I may decline to have these individuals involved in my care and this will not affect my care or treatment.

### **Assignment of Benefits/Payment for Services**

I authorize South Lake Pediatrics to directly bill my health plan or third-party payor for services rendered to me or my child by or on behalf of South Lake Pediatrics but acknowledge that South Lake Pediatrics is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a third-party payor. I also authorize any third-party payor through which I or my child may have benefits to make payment directly to South Lake Pediatrics for such services. I agree to abide by the attached Financial Policy and acknowledge that I must pay for any charges for my child's care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with South Lake Pediatrics to get payment for such care. If I am eligible for payment from more than one type of coverage, South Lake Pediatrics will return any extra payments to the appropriate payor. If I have an unpaid bill at South Lake Pediatrics, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from South Lake Pediatrics.

### **Patient Rights and Privacy Practices**

You and your family's rights and our privacy practices are posted in main areas within South Lake Pediatrics and online at <https://www.southlakepediatrics.com>. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or South Lake Pediatrics' Privacy Officer.

### **X-Ray & Reference Laboratory Services**

I understand that if my child receives an x-ray as part of his/her diagnosis or treatment, the x-ray will be reviewed by an outside radiologist. I understand that blood and other specimens may be sent to an outside laboratory for testing. I further understand that the radiologist and reference laboratory will bill separately for their services. I consent to South Lake Pediatrics supplying the radiologist and/or the reference lab with my demographic information as necessary for billing purposes.

### **Non-Violence Philosophy**

South Lake Pediatrics recognizes that it is in the best interest of the community, employees, customers, and the organization as a whole to maintain an environment which is free from violence and harassment. Threats, harassment, aggressive or violent behavior by employees, patients, parents, visitors or others will not be tolerated. South Lake Pediatrics will hold all individuals responsible for the effect their behavior has on the clinic.

### **Cancellation of Appointments**

I understand that I must give the clinic a 24-hour notice of any canceled appointments. If I fail to keep my scheduled appointments, I may be at risk of not receiving future services.

### **Late Arrival to your Appointment**

I understand that if I arrive more than 15 minutes late to my appointment, I may be required to reschedule my appointment.

### **Release of Information**

I consent to and authorize South Lake Pediatrics to use and disclose my protected health information for:

- Treatment, including making disclosures to other health care providers being advised of or consulted in connection with my child's treatment or care.
- Payment, including making disclosures to a health plan, insurer, third-party payor, third party administrator or other organization providing me or my child with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews.
- Healthcare Operation Purposes, including making disclosures to third parties for care coordination and quality assessment and improvement activities.

In addition, I consent to the following releases:

- To a health information exchange where my information may be shared with and accessed by other health care providers and health care related entities for purposes of treatment, payment, and the health care operations of the participating organizations.
- To a record locator service or patient information service, **unless** I inform South Lake Pediatrics in writing that I wish to opt-out of sharing.
  - NOTE: "Record locator services" and "patient information services" help enable health information exchange among unrelated health care providers. These services are used by health care providers to electronically search for and locate the health records of their patients that are held by other health care providers.

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, to organizations providing electronic medical record or patient portal services, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and business associates of South Lake Pediatrics. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to South Lake Pediatrics and/or a clinically integrated network or accountable care organization in which South Lake Pediatrics participates.

### **Financial Policy**

It is the commitment of this office to help keep your health care costs as low as possible. In order to do this, we need to keep our billing costs at a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Please notify us immediately of any changes in insurance, address, phone #, etc.
- Please be prepared to pay your co-pay at the time of service; or if you do not have insurance, to pay for your visit in full.
- Please pay your bill in full when you receive your statement or make payment arrangements with the Patient Account Services department.

If you are unable to pay any balance due and would like to discuss payment arrangements, please contact South Lake Pediatrics' Patient Account Services department at 952-401-8282. We will work with you to avoid collections. Overdue accounts may be turned over to an outside collection agency, which will result in you incurring a collection fee as listed below based on the past due account balance, but in no event more than the maximum fee allowed by law. Parents/Guardians will be responsible for all additional fees and expenses

incurred as a result of trying to collect a past due balance. Failure to resolve a collection agency balance may result in termination of care at South Lake Pediatrics.

Account Balance	Collection Fee
\$.01 - \$250	\$25
\$250.01 - \$500	\$50
\$500.01 +	\$100

The legal parents/guardians are responsible for full payment (regardless of insurance coverage) and will be set up as the person who receives the bill (guarantor) and must provide complete demographic information including both parents' dates of birth and social security numbers, current address and telephone numbers. South Lake Pediatrics will not be involved in negotiating between parents/guardians in disputes. In order to change a guarantor, the person who will receive future bills must complete and sign a Change of Guarantor Form.

Parents/Guardians are responsible for knowing their insurance benefits. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. The patient/parent/policyholder is responsible to know the benefits of their health plan. South Lake Pediatrics cannot change coding in an attempt to obtain payment.

- Hearing and vision exams are often not covered as well as supplies such as slings and braces.
- Mental Health benefits are often different than medical benefits. Common conditions such as ADHD, Developmental Delays, Learning Disorders, Depression, Autism, Anxiety, and others are usually considered under the mental health benefits of an insurance plan. This is especially true for Psychological Testing.

Strep test visit is considered a nurse visit and an office visit charge will apply in addition to the charge of the lab test(s).

During a periodic health exam additional tests or procedures may be ordered such as hearing and vision screening, immunizations and laboratory tests. These are each separately charged. According to AMA guidelines, when a patient presents for a periodic health exam with concerns that require evaluation beyond the scope of a routine periodic health examination, the coding must be adjusted to reflect the additional services performed. The coding used to report these services is not covered by insurance carriers as a periodic health exam. These services are subject to any copay, deductible, or policy restriction that may exist. Further definitions of these criteria may be discussed with your physician or nurse practitioner.

A clear understanding of our financial policy is an important part of our professional relationship. We are pleased to discuss the financial aspect of your care. Feel free to contact our Patient Account Services department for questions regarding fees, financial responsibilities, or our Financial Policy.

My signature here means I have read the information on this form and have received a copy of the South Lake Pediatrics Financial Policy on the Patient Portal and agree to be bound by its terms. This consent is valid until revoked in writing.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Name of Who is Completing this form:** \_\_\_\_\_

**Signature of Patient (if over 18) or Legal Parent/Guardian:** \_\_\_\_\_

**Name of Interpreter (if used to complete this form):** \_\_\_\_\_