Premier Care Pediatrics
Where your family comes first

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PARENT(GUARANTOR)/PROVIDER AGREEMENT

*Please read the following items **carefully** and **thoroughly**. It is your responsibility to know the details of your insurance policy.*

FINANCIAL AGREEMENT*

- ✓ **INSURANCE CARDS MUST BE PRESENT AT EVERY APPOINTMENT.**
- ✓ Insurance eligibility will be verified prior to the appointment.***IF INSURANCE IS FOUND TO BE INACTIVE***, verification from your insurance carrier or case worker will be required. If you are unable to obtain this, you will be considered SELF PAY and will be required to pay at time of service or you may reschedule your appointment.
- ✓ **COPAYS** are due at the time of service prior to your child being seen by the physician.
- ✓ Payment in**FULL**is due when you receive your billing statement. If you are unable to pay your balance in full, please contact our patient account specialist (located in our office).
- ✓ **PENDING STATUS**. Newborns whose insurance is in a pending status will have 60 days before status will be changed over to SELF PAY. After this time, verification of coverage will be required or payment at the time of service will be expected. Should the insurance become active and retroactive payments are received, a refund will be issued.
- ✓ **NO INSURANCE.** We offer a 15% discount for *payment in full at the time of services.*
- ✓ Balances that remain unpaid at 120 days may be referred to a collection agency. I understand that in the event any unpaid balance is placed for collections within any third-party collection agency a fee of **50%** of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and other fees stated elsewhere. The authorized fee of **50%** and the additional costs and charges listed above represent the actual costs incurred by Premier Care Pediatrics to collect amounts owed under this agreement and corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.
- ✓ Refunds**:**If a refund is due and there are no outstanding balances, we will attempt to provide you a refund within 30 days.

POLICIES

- ✓ **LATE ARRIVALS, MISSED APPOINTMENTS, OR LATE CANCELLATIONS:** If you are more than **15 minutes late** for your appointment, you will be required to reschedule. Reminder phone calls are a **courtesy** only. It is your responsibility to keep track of your appointment times. If you are unable to keep your child's appointment, please be respectful and call to cancel or reschedule so that another patient may have the opportunity to utilize that opening.
- ✓ **MINOR CHILDREN:** All children under 18 must be accompanied by an authorized adult/guarantor listed in the patient's account.Exceptions with written documentation from parent/guardian assuming responsibility prior to appointment may be allowed.A parent/guardian must be present for Behavioral Health appointmentsand medication follow ups.
- ✓ **PRESCRIPTIONS/MEDICATIONS:**Antibiotics **will not** be called to a pharmacy without having seen your child. **Allow 48 hours** for us to complete prescription refill requests. Refills **cannot be filled earlier than 3 days from the previous month's refill**. We **require** regular visits every six (6) months for re-evaluation of chronic or recurrent conditions, including but not limited to asthma and ADHD.
- ✓ **MEDICAL RECORDS:** Requests for medical records and/or immunizations requires a **minimum of 3 business days to process**. If medical records are not being faxed to another provider for a referral,we will need a Release of Information (ROI) signed.
- ✓ **IMMUNIZATIONS:** We firmly believe that vaccinating is a key element to your child's health in the prevention of serious life-threatening illnesses to them and to others in the community. We follow the recommendations of the American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the vaccine schedule published by the CDC. Vaccine Information Sheets are available in the office. Any family choosing not to vaccinate will be asked to find a newprovider.
- ✓ **BEHAVIOR:**You, your family members, your friends, and any other accompanying persons are required to treat all staff at Premier Care Pediatrics with the utmost respect. **Disrespectful behavior, whether on the phone or in person, will NOT be tolerated. Posting of demeaning, disparaging, or malicious comments on social media will not be tolerated.These are considered serious offenses and will result in prompt discharge of your child/children from the practice.**
- ✓ **TRANSFER OF CARE:** Transferring care back to the practice after choosing to switch providers is at the discretion of Dr. Garver.
- ✓ **DISCHARGE FROM PRACTICE:** Failure to pay your bill or follow payment plan, failure to comply with provider's treatment plan, 2 or more No Shows (per family), no showing for your initial visit, **disrespectful behavior**, and **posting of demeaning, disparaging, or malicious social media comments** are grounds for discharge from our practice. You will be notified by certified mail and will need to obtain a new provider for medical care. The provider, as per legal obligation, will ONLY treat on an emergency basis for 30 days. You will still be responsible for any balance owing on your account.
- ✓ **POLICY CHANGES:** This policy is effective *May 20, 2021* and may be revised as needed.

I verify that I have read and understand all Premier Care Pediatrics current policies and agree to abide by them.

PARENT/GUARANTOR'S SIGNATURE:_____ DATE:_____

PARENT/GUARANTOR'S PRINTED NAME:_____

**Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.*

Disclosures and Consents

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Premier Care Pediatrics for services rendered to my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that my insurance carrier has determined should be payable to Premier Care Pediatrics.

MEDICAID/TRICARE INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my dependent's authorized benefits be made directly to Premier Care Pediatrics on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy Premier Care Pediatrics' Notice of Privacy Practices. I hereby authorize Premier Care Pediatrics to release any of my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO RELEASE IMMUNIZATION INFORMATION:
I authorize Premier Care Pediatrics and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care provider to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with the state immunization requirements. I understand that I have the right to rescind this authorization at time by notifying Premier Care Pediatrics to that effect in writing.

AUTHORIZATION TO MAIL, CALL, TEXT, OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, texts, and e-mails. I hereby authorize Premier Care Pediatrics Representative or my physician to mail, call, text, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, billing notifications, referral arrangements, laboratory results and surveys. I understand that I have the right to rescind this authorization at any time by notifying Premier Care Pediatrics to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services from another facility. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee at Premier Care Pediatrics.

PARENT/GUARANTOR'S SIGNATURE _____ DATE: _____