Children's Clinic of Wyomissing
2240 Ridgewood Road, Suite 100
Wyomissing, PA 19610
(610) 376 8691 / Fax (610) 376 8745

Protection of Identity Theft, HIPAA Disclosure, Other Party Authorization to treat & Financial Acknowledgment

Thank you for choosing Children's Clinic of Wyomissing as your Pediatric provider. We have established an identity Theft Prevention & Detection Program to detect & prevent or mitigate the theft of patients' financial & other identifying information. Medical identity theft is a serious problem. It can result in adverse financial consequences to the practice and to our patients. In addition, if it results in incorrect information being included in a patient's medical record, it can lead to inappropriate medical care. ALL parties are to present our office with picture ID (driver's license, passport, green card, employee ID card, or students ID card) as well as their insurance card which will be scanned in to our system for identification purposes & to assist with possible red flags & identify theft. Furthermore, in signing this form, you consent to the use & disclosure of your protected health information by Children's Clinic of Wyomissing, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

Furthermore, in signing this form, you consent to the use and disclosure of your protected health information by Children's Clinic of Wyomissing, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our *Notice of Privacy Practices* prior to signing this consent. We encourage you to review our *Notice of Privacy Practice*s carefully. It provides more detail on how we may use and disclose your information.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the *Notice of Privacy Practices* for further information.

It is our hope that our patients understand our credit, collections and office policies are a necessary part of assuring the financial resources required to maintain vital health care service for our patients and the community. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Authorization for Credit Card on File Program – Optional – If not interested please leave this section blank. **Rest of the form must be completed.**

We are excited to offer an innovative program to help manage your health care dollars. With the changes in healthcare, many families have chosen individual high deductible health plans to help lower their monthly insurance premiums. With the Credit Card on File program we will process any amounts that your insurance carrier deems as your responsibility. Your credit card information is not stored in this office. We use a secure clearinghouse that meets the industry standards set forth from the Payment Card Industry Data Security Standard (PCI-DSS). Once we enter your information through this gateway, we do not have access to view or edit the information.

AUTHORIZATION

I authorize Children's Clinic of Wyomissing to charge all balances applied to co-pay's, deductible or denied for non-payment of insurance premiums or any other reason for the patients listed below to the following credit card:

Last 4 digits of credit card: _____ _____ _____ _____ Expiration Date: _____
I understand that once my health insurance has processed my child's claims, I will receive an Explanation of Benefits (EOB). The EOB will show any balances due that are patient responsibility. I agree that Children's Clinic of Wyomissing may charge my credit card on file for the balance due when they receive the EOB from my health plan. **If the balance due is more than $200.00, I will receive a courtesy call prior to my card being charged.** I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further appointments until the balance has been paid in full.

Signature:_____

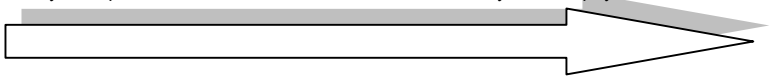
Appointments:

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate no less than 2 hour cancellation notice. Please remember that all of our appointments are scheduled appointments and if notice is not received no-show and late cancellation fees will apply and are as follows: **$50.00 well visit** and **$30.00 all other appointments.** If there are 3 no shows within one year you will be asked to transfer care to another practice.
- If you are late for your appointment (>10 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- To accommodate working families we have extended evening (after 6PM), weekend and holiday hours. Please note that there is additional charge of **$50.00** for those appointments. Your insurance company will pay for those visits according to your benefit grid.
- All children under the age of 18 must be accompanied by an adult.

Initial:_____

Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you come prepared to present your insurance card at every visit to verify that our office has the most updated card on file.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- As we are your primary care provider, make sure our name/phone number appears on your most up to date card. If your insurance has not been informed that we are your primary care provider and we cannot confirm that we are, you must pay for the visit or reschedule.



- It is your responsibility to understand your benefit plan. **Well Appointments –** <u>According to children's age there are surveys that will be required for you or your child to complete. They are a necessary part of the visit and are standard of care. The survey must be billed and charged under individual billing code separate from the well visit code. If these services are not covered, you will be responsible for payment.</u>
- Not all plans cover well child visits, vision/hearing screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

Initial:_____

Referrals:

- Advance notice is needed for all non-emergent referrals, typically 3 business days.
- It is your responsibility to know if a selected specialist or lab participates with your insurance.

Initial:_____

Financial Responsibility:

- We do not get involved with domestic disputes and custody issues. Our policy is to obtain payment at the time of service from the parent/guardian bringing the child to the office. The person who the patient resides with is responsible for any balances due upon receipt of a statement.
- According to your insurance plan, you are responsible for any and all co-pays, deductibles, and coinsurances.
- Co-pays are due at the time of service. A **$15.00** billing fee will be charged in addition to your co-pay if co-pay is not paid at the time of service.
- Self-pay patients are expected to pay for services in full at the time of visit. This includes patients that we do not participate in their insurance plan. Our office will be happy to furnish a print out with all the necessary codes for you to file the claim for reimbursement with your insurance company for which we do not participate.
- Patient balances are billed bi-weekly and we ask that you pay your statement balance in a timely manner.
- If previous arrangements have not been made with our billing office, any account balances over 30 days old will be forwarded to a collection agency with an additional **$50.00** administrative collection fee charge. If your account is sent to Collection Company you will be asked to transfer your care to another practice.
- For scheduled well appointments, any outstanding balances must be paid prior to the visit or you will be asked to reschedule.
- We accept cash, check, and all major credit cards.
- A **$30.00** fee will be charged for any checks returned for insufficient funds or any other reason the check would be declined, Checks will no longer be permitted as a method of payment.
- Children's Clinic of Wyomissing reserves the right to change fees without notice.
- Any families asked to transfer care for non-compliance of our policies will not be accepted back in to our practice.

Initial:_____

Forms:

- We require a 48 hour turnaround time.
- $5.00 Fee for school, camp and utility form.
- $10.00 Fee Cyber School forms
- $20.00 Fee for PIAA, college, FML, disability forms and letters.

Initial:_____

Medical Records:

- CD copy of medical records and transfers are **$25.00**. If mailing of the record is necessary an additional certified, return receipt mail fee is assessed according to USPS fees.
- The fee must be paid at time of request. For your convenience the following forms of payment are accepted; Cash, Personal Check, Visa, Master Card, American Express and Discover.
- If the patient is over the age of 18 we will only release the records to the patient unless there is a written permission to release to other individuals.

Initial:_____

Prescription Refills:

- For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial:_____

Patient Name - list all children that are patients at CCW

1. _____ **DOB** _____

2. _____ **DOB** _____

3. _____ **DOB** _____

4. _____ **DOB** _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

Signature of responsible party: _____**Relationship to the child:** _____ **Date:** _____

For Practice use only
Failure to obtain consent Check the appropriate reason:
☐ Indirect Treatment Relationship ☐ Emergency treatment
☐ Substantial Communication Barrier ☐ Refusal to Sign ☐ Other Staff Name:_____Date:_____