Patient Responsibility Agreement

Patient Name: _____
Date of Birth: ___/___/___
Name of Siblings: _____
Date of Birth: ___/___/___

Please read and sign the following agreement:

1. **Demographic Information:**
   We rely on our patients to keep us up-to-date with your family's personal information. It is your responsibility to contact our office should any of the following change: Home address (No P.O. Box information will be accepted without a valid home address.), current phone numbers for both parents, and Emergency contact information.

2. **Insurance Information:**
   We understand that your health insurance information may change from time to time, however, it is your responsibility to contact our office immediately should any changes occur. Should you fail to provide us with the most accurate information in a timely manner you will be responsible and billed for all charges that result in non-payment or denial by your insurance company. An invoice will be sent to you and payment is expected within 30 days of receipt.

3. **Payments:**
   All copayments are due at time of service.
   The person bringing the child(ren) to the office for their appointment is responsible for any and all payments due at the time of the appointment. This means that all co pays or unpaid deductibles are due the day of your child(ren)'s appointment(s). Failure to submit payment could result in a $5 billing fee to cover the cost of an invoice being sent to your home.

4. **Appointments:**
   An annual exam visit does not include the discussion of new problems or detailed review of and/or management of chronic conditions. While the appointment may have been scheduled as a routine physical, should a problem or chronic problem be addressed and treated and both services are preformed during your visit, then both services may be billed. We are legally obligated to assign procedure codes based on the services provided to you, whether it is an "annual physical", a visit to take care of problems, or both. This billing standard may create additional out-of-pocket expenses, such as copay or deductible, depending on your coverage.

If you prefer to have your annual exam scheduled as strictly a preventive service, a separate follow up visit for your other concerns will be scheduled and billed accordingly.

We work diligently to stay on schedule and ask that you arrive 10 to 15 minutes prior to your appointment time to fill out any necessary paperwork. If you will be more than 5 minutes late for your appointment, we request that you call our office to inform us. If you arrive more than 15 minutes after your appointment time, your appointment may be canceled and you will have to reschedule for another date and time. If you are unable to make your well child visit, we require you to cancel a minimum of 24 hours in advance. If we do not hear from you or you do not call to cancel your appointment, a $25 fee (per person) will be charged to your account. More than 2 no-shows could result in discharge from our practice. If you are a new patient and you fail to show up or cancel your appointment within 24 hours, a $50 fee (per person) will be charged to your account and will have to be paid before an appointment can be rescheduled. More than 1 no-show of a new patient appointment will result in discharge from our practice.

5. **After Hours Phone Calls**

Delaware Pediatrics strives to provide comprehensive care to all of our patients even after our office is closed. We have a provider on call 24/7 when the office is closed.

Please keep in mind that after hour calls are for **EMERGENCY QUESTIONS/CONCERNS ONLY**. Please call back during normal business hours for all non-urgent requests.

If you need to contact our after-hours service, should you have an urgent matter, please call our answering service at (716) 827-1621. Please allow up to an hour for a return call from the covering provider.

6. **Explanation of HDHP (High Deductible Health Plan) (Medical Care/Services):**

The providers at Delaware Pediatrics are well aware of increasing insurance deductibles and co pays for medical care. We urge each family to familiarize themselves with the requirements of their specific insurance plan.

Please be aware that a medical service MAY go towards your deductible or generate a co pay, even if this service is provided at a routine well visit. An example of this would include a child being seen for a well visit, during which time an acute problem is identified and treated. We are required to report these additional diagnoses to your insurance company and are prohibited from

"adjusting" or "writing off" any charges generated, as this would be considered insurance fraud.

We understand that these are financially challenging times, however, we want to provide the best medical care to your family in a timely manner. We thank you for your cooperation in this matter.

The following services may not be covered or could generate a co pay depending on your insurance coverage or if you have a "high deductible" plan:

After Hours Charges

For the convenience of our patients, and at the request of various insurance companies, Delaware Pediatrics offers after-hours appointments Monday through Thursday from 5pm-7:30pm.

Some insurance companies may charge an additional fee for "after-hours" visits as well as Saturday morning visits. Please check with your health insurance company for details regarding your coverage.

Developmental Screening Assessments

Our office follows the American Academy of Pediatrics recommended screening schedule for autism and depression. Autism screening takes place at the 18 month and 24 month visit, while depression screening is done yearly starting at age 12. Please be advised that some insurance companies may not cover this service and you may be charged for this, even if it is done as part of the routine well visit.

Vision Screening

Our office uses an Ocular PhotoScreener to check your child's vision. Please be advised that some insurance companies may not cover this service and you may be charged for this, even if done as a part of the well visit.

Lab Orders

Your insurance company may limit where you can get your blood work done. Please be advised that, your insurance company will not cover your lab work if you use the wrong laboratory. Please contact your insurance company to assure you do not encounter any unexpected charges or fees. **Delaware Pediatrics will not be responsible for any unpaid balances in the event that you use the wrong laboratory.**

7. **Forms:**

Due to the time required to complete forms Delaware Pediatrics charges a $5 fee for any physical forms, daycare forms, and FMLA paper work. If you bring physical forms or daycare forms with you on the day of your appointment, we will provide you with a FREE health appraisal or daycare form in its place. Please note that not all institutions will accept our health appraisal form in lieu of their own form. If this is the case, the $5 form completion fee will apply. Please check with your child's school or daycare provider before your appointment. FMLA paperwork can take from 7-14 days to be completed. Any forms being requested after your well visit can take up to 5-7 business days to be completed.

8. **Collections:**

You are responsible for any fees associated with the collections process. Delaware Pediatrics reserves the right to refer your account to a third party for collection of any account balances that have gone unpaid for 120 days. Should your account go into collections, you will be asked to leave the practice and have 30 days to find a new pediatrician. We will send you a written notice of the above along with the necessary forms to request your child's medical records.

9. **ACKNOWLEDGMENT OF "ABUSE FREE ZONE"**

At Delaware Pediatrics we appreciate and respect our staff. It is our belief that our staff should have an environment free from verbal and physical abuse. We expect you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your discharge from our practice.

PATIENT RESPONSIBILITY/FINANCIAL:

I have read the above and understand and accept the terms of the Patient Responsibility/Financial Agreement. I also understand that I will be responsible for any and all collection fees should I fail to make payments in a timely manner.

_____

(Print Name)

_____ _____/_____/____

Parent/Guardian Signature Date Signed

Employee Initials: _____