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**PATIENT ACKNOWLEDGEMENT OF OFFICE POLICIES**

**Insurance Information – Co-payments, Co-insurance, Deductibles and Balance Owed**

Stone Oak Pediatrics will file your claim with your insurance if we participate with your insurance plan; otherwise, payment is required in full for all services at the time they are rendered. Should any services not be covered by your insurance, you agree to accept financial responsibility for said services. All applicable co-payments, co-insurance and deductibles and balance owed on your account are to be paid in full and collected at each and every visit. If you have not made arrangements with our Billing Department, prior to your visit, you will be asked to reschedule your appointment.

Patient statements will be mailed to you every thirty days. If you have not paid your balance owed to us by the tenth day after the third statement is due, your account will be placed with our collection agency. At that time, your account will be assessed a 35% fee on the balance owed, for which you are responsible to pay, alone with the balance owed on your account.

If you have made arrangements with our Billing Department for a payment plan, you will be required to make your installment payment every month. In the event that you miss one payment, your account will be placed with our collection agency. At that time, your account will be assessed a 35% fee on the balance owed, for which are your responsible to pay, along with the balance owed on your account.

In the event of a default on any payment due to Stone Oak Pediatrics, you will agree to pay all costs of collection (35%) of balance owed. Returned checks are subject to a $30.00 administrative fee. Your signature below signifies your understanding and willingness to comply with this policy.

**Contact Information**

If you are providing a Cellular phone number as a way to contact you, you are preauthorizing Stone Oak Pediatrics to contact you at this phone number.

**Insurance Cards and Photo Identification**

All patients are required to provide valid insurance card(s), or a temporary print out at the time of their visit. Should you be unable to produce this documentation, insurance regulations require that you sign a financial waiver. All patients are also required to provide photo identification. Your signature below signifies your understanding and willingness to comply with this policy and that you are responsible for notifying our office of any changes to your insurance or contact information.

**Cancellation Policy**

We require a 24-hour notice to cancel our reschedule a Well Child appointment that has been reserved for you. If you do not provide a 24-hour notice, you may be charge a fee of $50 for the Well child appointment. Regretfully, we have been forced to institute this policy due to the large volume of last-minute cancellations and “no-shows.” These fees are not reimbursable by your insurance company.

**HIPAA Policy**

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Stone Oak Pediatrics from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often this causes difficult for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.

Name Of Individual Relationship To Patient

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May we release Medical Information to: \_\_\_\_\_\_ Voice Mail at Home \_\_\_\_\_\_ Voice Mail at Work \_\_\_\_\_\_ Voice Mail On Cell Phone

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name If Patient Is A Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_