Mt. Spokane Pediatrics
Office Policies, Consent to Treat & HIPAA Notification

YOUR INFORMATION: Please provide your most current contact information such as home and cell numbers and address. Also, please bring your **insurance card to EACH VISIT** to ensure accurate filing and payment from your insurance carrier.

CELL PHONE USAGE: Please refrain from using your cell phone when your child is in the exam room with our staff and when checking in or out of the office.

WALK-IN-POLICY/APPOINTMENTS: Patients with pre-scheduled appointments are seen Monday through Friday from 8am-5pm. If you have an appointment scheduled for one child and would like and additional child to be seen, please make every effort to call in advance. We will do our best to accommodate you. Please provide a 24-hour notice if an appointment needs to be cancelled.

PRESCRIPTION REFILL/FORM COMPLETION: Please allow 48 hours for all forms to be completed, and prescription refill request to be processed. Please note that in compliance with Federal Law, some medication prescriptions must be picked up at our office. These prescriptions will not be sent electronically or called in to your pharmacy. You will be notified in advance if this is the case. Please be prepared to show identification, if requested, when picking up these prescriptions

CONSENT TO TREAT:
I am the parent or legal guardian for the patient(s) listed below and am on the patient(s) behalf, hereby request and consent to the children listed below, to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the patient's care. I understand treatment and services may include:
- Lab tests
- Screening tests (tests that can identify an illness early, before a person shows signs of having the disease)
- Diagnostic tests (tests that shows if a person has a certain illness or health problem), and routine exams
- Immunizations as recommended by American Academy of Pediatrics

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(Initial)

TREATING MINOR WITHOUT A PARENT OR LEGAL GUARDIAN
I, ______________________ (parent or guardian), authorize treatment of the minor patient when accompanied by the following decision-making persons at their appointments:
____ [name, date of birth]
____ [name, date of birth]
____ [name, date of birth]

PAYMENT/RESPONSIBLE PARTY:
Please pay the co-pay your insurance requires and any outstanding balance at the time of your visit. **Please contact your insurance company to verify the benefits available including well baby care and vaccinations.** It is the responsibility of the guarantor to pay any outstanding charges not covered by their insurance carrier.

DELINQUENT ACCOUNTS: all accounts are due and payable within 30 days of services rendered. A $25.00 returned check fee applied to any check returned by the bank. A finance charge of $3.00 per month will be assessed on unpaid accounts over 60 day's pas due (regardless of the account balance). Unless a payment schedule has been arranged with the billing department, accounts left unpaid after 120 days will be turned over to an agency for collection follow-up and may result in dismissal from our practice of all children for whom you are the guarantor.

AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER.
I (the legal guardian and/or financial responsible party) hereby authorize the office of Mt. Spokane Pediatrics to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, and unmet deductible for care rendered regardless of insurance coverage.

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(Initial)

I have received or reviewed a copy of Mt. Spokane Pediatrics Notice of Privacy Practices (HIPPA)

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(Initial)
PLEASE SIGN BELOWTO VERIFY THAT YOU HAVE READ AND UNDERSTAND
MT. SPOKANE PEDIATRICS OFFICE POLICIES, CONSENT TO TREAT, AND HAVE
REVIEWED THE PRACTICE'S NOTICE OF PRIVACY PRACTICES (HIPPA)
Signature of Patient, Parent or Legal Guardian: ______________________________
Printed name of person signing and relationship to patient(s)__________________
Child/Children(s) Name
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Date:_______________