Mt. Spokane Pediatrics

Office Policies, Consent to Treat & HIPAA Notification

Patient Name: _____ **Patient Date of Birth**: _____

Your Information: Please provide your most current contact information such as home and cell numbers and addresses. Please list all of the patient's legal guardians on the intake form and provide legal documentation when there are changes to the patient's current legal guardianship. Also, please bring your insurance card to each visit to ensure accurate filing and payment from your insurance carrier.

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 an additional child to be seen, please make every effort to call in advance. We will do our best to accommodate you but cannot guarantee we will have an opening in our provider's schedule.

Cancellation/No call No Show Policy: Please provide 24-hour notice if an appointment needs to be cancelled. If you neglect to keep your scheduled appointment or provide appropriate notice of a cancellation, you may be charged a $25 missed appointment fee. After three missed appointments, the patient may be discharged from our clinic.

Prescription Refill/Form Completion: Please allow 48 to 72 business 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.

Communication via Texting: Our office utilizes a texting application to provide a convenient way for patient's to be reminded of upcoming or overdue appointments. Patient's may also be choose to communicate with our office via text messaging to discuss medication refill requests, appointment scheduling, lab results, home care instructions, insurance or contact information updates, questions about new or worsening symptoms, and more. Texts will only be sent or responded to if the phone number is documented in the patient's chart as their own, as that of a legal guardian's or as that of an approved adult's. Anytime a text message communication is initiated, it will require the recipient to verify their understanding that communicating via text is not Hipaa compliant and that they consent to continuing the communication. All communication will be documented in the patient's chart and the verification and consent will be required with every new communication.

Cell Phone Use/Photography: Please refrain from using your cell phone when your child is in the exam room with our staff and when checking in or out at the front desk.

Service Animals: Animals are not allowed in the office unless they are a licensed service animal, trained to perform a service for their owner. Therapy animals or Emotional Support Animals, are not allowed in

the office. If you plan to bring a trained service animal to your child's appointments, please provide a copy of the animal's license or certification as a registered service animal.

Well Waiting Room Waiver: In consideration for utilizing the well waiting room at Mt. Spokane Pediatrics, PLLC, I hereby agree on my behalf and on behalf of the minor listed on this form to the following: I understand that the well waiting room is unstaffed and it is my responsibility to supervise the children in my care when they are playing, not the responsibility of Mt. Spokane Pediatrics staff. I understand that while the purpose of the well waiting room is to avoid illness, avoiding contraction of illness cannot be guaranteed.

Payment/Responsible Party: Co-pays are due at the time of service as well as any outstanding balance. **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 will be applied to any check returned by the bank. 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 financially 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)

Well Child Visit vs. Sick Visit: The purpose of Well Child Visit is to keep children adequately protected against diseases, address potential health concerns, and discuss normal and unusual development. A typical Well Child Visit may include, but is not limited to checking growth and development, physical assessment, immunizations, parental concerns about growth and development, nutrition counseling, physical activity counseling, and age specific exams may include- hearing and vision screening and developmental screenings, such as a questionnaire for indicators of autism. Generally speaking, there are no co-pay requirements for a Well Child Visit (this does not apply to all self-funded insurance plans). Mt Spokane Pediatrics is required, under contract with your insurance carrier, to collect co-pays if anything outside the scope of a Well Child Visit are addressed during your appointment. This may include, but is not limited to; illness, infections, medication modifications, or chronic illnesses (such as allergies, asthma, ADHD, or diabetes). Requesting or approving treatment for an acute or chronic illness during a Well Child Visit will trigger a copayment charge. Some insurance companies will not cover both

visits at the same time of service, therefore, we may advise you to adjust the visit and reschedule one or the other.

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(Initial)

Consent to Treat: I am the parent or legal guardian for the patient listed on this form and on the patient's behalf, hereby request and consent to the child listed on this form, 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 before showing signs of having the disease), Diagnostic tests (tests that show 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)

HIPAA Notification: A copy of HIPAA Notice of Privacy Practices has been made available to me for review and I understand I may request a copy at any time.

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(Initial)

I HAVE READ AND UNDERSTAND MT. SPOKANE PEDIATRICS OFFICE POLICIES, CONSENT TO TREAT, AND HAVE REVIEWED THE PRACTICE'S NOTICE OF PRIVACY PRACTICES (HIPAA)

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Printed Name (Parent/Legal Guardian) **Signature (Parent/Legal Guardian)** **Date**