NORTHWEST SUBURBAN PEDIATRICS, S.C.

GROW WITH US

Patient Agreement

Initial _____ **INSURANCE PLANS:** I understand it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen under "out of network" benefits.

Initial _____ **COVERAGE:** I acknowledge that Northwest Suburban Pediatrics, S.C. is not responsible to know what services my insurance covers. I shall direct questions regarding health insurance policy coverage to my insurance company.

Initial _____ **FINANCIAL COMMITMENT:** I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan at the time of my visit. If I do not have a copay or have not come prepared to pay past due balances, my child's appointment may be rescheduled for a later time. Furthermore, I understand that if someone other than me is bringing my child to Northwest Suburban Pediatrics, S.C., they will be responsible to pay for copays and any past due balance. Even in divorce situations, we consider both parents responsible for the account. In the event the account is referred to a collection agency a 30% collection fee will be assessed, both parent's names and social security numbers will be submitted.

Initial _____ **NO INSURANCE AT THE TIME OF SERVICE:** If proof of insurance coverage cannot be determined at the time service, I understand that payment is required at the time services were provided. In some circumstances, I may have the option to put a credit card or debit card on hold until I'm able to provide proof of insurance.

Initial _____ **PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. Any balance remaining after my health insurance processes a claim is my responsibility.

Initial _____ **SERVICE FEES:** I understand my account will be charged $35 for NSF/Returned checks.

Initial _____ **PERMISSION TO TREAT:** I give permission to Northwest Suburban Pediatrics, S.C. to render treatment to my minor children.

Initial _____ **APPOINTMENTS & LATE ARRIVALS:** I understand that it is important to arrive on time for my appointment. I'm also aware that if I arrive more than 15 minutes past my scheduled appointment time, the practice may have to reschedule my appointment.

Initial _____ **NO SHOWS:** I commit to give Northwest Suburban Pediatrics, S.C. at least 24 hours notice if I am unable to keep my scheduled appointment. I understand Northwest Suburban Pediatrics, S.C. does charge a $25 fee for no-shows if practice is not notified; however, if I miss 3 appointments without notifying the practice in a 12 month period, the practice will no longer be able to continue providing pediatric healthcare services and I understand I will be dismissed from the practice.

Initial _____ **MINORS:** If my child is not accompanied by a legal guardian, I agree to provide written authorization for medical treatment so that treatment can be rendered. I also agree to be available by telephone in the event that the physician needs to contact me.

Initial _____ **PRACTICE ACKNOWLEDGMENT:** I have received the notice of privacy and I have been provided an opportunity to review it.

Initial _____ **AUTHORIZATION TO RELEASE INFORMATION TO THE INSURANCE CARRIER:** I hereby authorize Northwest Suburban Pediatrics, S.C. to release any information required in the course of my examination or treatment which could include HIV, communicable disease or drug abuse information.

I have read, understood and agree to the above financial and office policy. I understand that **Non-compliance with this policy may result in a dismissal from Northwest Suburban Pediatrics, S.C.**

Patient Name: _____ **DOB:**_____/_____/_____

Sibling Name: _____ **DOB:**_____/_____/_____

Sibling Name: _____ **DOB:**_____/_____/_____

Parent or Guardian's Signature:_____ **Date:**_____/_____/_____

Staff Only: Date Completed: Reviewed by: (initials only)