valley pediatrics of greenwich

**Today's Date:** _____

**Parent/Guardian Name:** _____

DOB: _____

Cell: _____

Home: _____

Work: _____

Email: _____

**Preferred Method of Contact:** _____

**Parent/Guardian Name:** _____

DOB: _____

Cell: _____

Home: _____

Work: _____

Email: _____

**Preferred Method of Contact:** _____

**Patients' Home Address:**

_____

_____

_____

**Billing Address for responsible party (if different from home):**

_____

_____

_____

**Primary Insurance**

Ins Company: _____ Effective Date: _____

Policy #:_____ Group #: _____

Subscriber: _____ DOB: _____ Employer: _____

**List all children:**

| Last name | First name | Nickname | DOB | Gender |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**In the case of an emergency, please contact (other than parents):**

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

# FINANCIAL POLICY

Patients are expected to pay for medical care (if you do not have insurance coverage) and insurance co-pays at the time of each visit.

Payments for unpaid medical care are due within 30 days of receipt of our statement for services.

Per your insurance plan, you are responsible for any and all co-pays, deductibles and co-insurance. Not all services provided by our office are covered by every plan. Any service not covered by your plan will be your responsibility and you will be billed. It is your responsibility to understand your benefit plan as this is an agreement between you and your insurance company.

Should families experience financial difficulties, they may make special arrangements with our billing department for timed partial payments of larger medical balances. Please contact us if you are in need of special arrangements.

**Co-pays are due at the time of service.** A $25 fee will be charged in addition to your co-pay if the co-pay is not paid at the time of service or by the end of business day.

**Please bring proof of insurance to each and every office visit!** We can not accept any insurance that can not be verified. We will have to bill you directly until you can provide proof of insurance. If the insurance that you designate is incorrect, you are responsible for any balance.

We do not submit to secondary insurance plans. At the end of the visit we will provide you with a detailed receipt for you to submit for reimbursement if you hold secondary insurance. **You are responsible for any balance on your account.**

Prior to making an annual physical appointment, please verify with your insurance company that the physical exam will be covered. **Most plans have restrictions as to how long you will need to wait between annual well visit checks.**

For all services rendered to minors, the adult accompanying the patient is responsible for payment, whether that adult is a parent/legal guardian or not. If your child will be brought to our office by a babysitter, grandparent, etc, please be sure to arrange for payment of co-pay and/or any balance on your account. Credit card payment can be made on the phone prior to the appointment or a credit card can be kept on file in our office. Additionally, if you have set up a portal account you can make a payment online.

We will bill monthly for unpaid balances. Should patients fail to pay their balance/set up a payment plan, we will attempt to also reach you by phone and/or email. If the balance remains unpaid & we have not heard back from you then we will be unable to make any future appointments.

Checks returned to our bank for insufficient funds will incur a service charge of $40 per incident.

**Valley Pediatrics of Greenwich requires 24hr change/cancellation notice for appointments.** There will be a $75 charge for any missed annual physical or consult appointment if no notice or late cancellation with less then 24hr notice. There will be a $25 charge for any missed sick visit appointment.

**I have received, and will abide by, the financial policy of Valley Pediatrics of Greenwich.**

Patient Name(s):_____

Responsible party member's printed name:_____

Responsible party member's signature:_____ Date:_____

# RELEASE STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party, hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I authorize the release and disclosure of any and all of my child's medical records to any other entity, including but not limited to, specialty physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and/or its employees to release, via fax machine or other encrypted methods, medical records which are needed in order to provide the patient with the most appropriate medical care.

I authorize and request that payment of any third party or insurance company benefits be made to this office for any services furnished to the patient. The signature below shall suffice for all insurance forms on a continuing basis.

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Signature of Responsible Party Date

# Consent for Treatment of Minor

I, _____, legal guardian

Give **the following adults** permission to make decisions regarding the necessary and/or routine treatment of my children including, but not limited to, examinations, injections, immunizations, and/or diagnostic procedures including X-rays or laboratory analysis. I understand that myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunization) or my teen (16 years or older) without requiring the presence of an adult. However, if my teen needs immunizations, and comes in alone, a parent/guardian must be available to phone for verbal consent.

**(I.E. NANNY, BABYSITTER, GRANDPARENTS WITH PERMISSION TO MAKE DECISIONS)**

| Name | Phone | Relationship to Patient |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me, or treatment may be refused or delayed. I understand that, in an emergency, efforts will be made to contact me prior to the rendering of medical treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Valley Pediatrics of any changes as to the health status of my children or the above information.

| Completed by: | Date: |
|---|---|
| Signature: | |

valleypediatrics of greenwich

PAUL E. JUAN, M.D.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients'Name(s):_____ _____

_____ _____

_____ _____

_____ _____

Relationship to patient(s):_____

Signature: _____

Date: _____

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**OFFICE USE ONLY**

I attempted to obtain the signature of the patient's legal guardian(s) on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initial:_____

Reason:

_____

_____