Financial Policy and Authorization

Pediatric Associates of Avon, P.C., 1115 Ronald Reagan Parkway, Suite 136, Avon, IN, 46123

1. **Authorization to Release Information and Assignment of Benefits** – I hereby authorize Dr. Jason Cosgrove, Dr. Eve Gill, Dr. Jessica Lopez, Dr. James Shmalo &/or any medical professional employed by them to apply for benefits on my behalf for medical services rendered by them or their employed medical professional. I request the payment by the insurance company be made directly to the Office of the Pediatric Associates of Avon, Dr. Cosgrove, Dr. Gill, Dr. Lopez &/or Dr. Shmalo. I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process the claim. I permit a copy of this authorization to be used in place of the original. I realize this authorization may be revoked at any time in writing.

2. **Agreement to Provide Payment for Services** – I hereby agree to provide verification of insurance and make any co payment before any service is rendered by the physicians, nurses or employees of the Pediatric Associates of Avon. I hereby agree to pay any & all office fees or charges not covered by my insurance company. I hereby agree to pay any & all office fees, legal fees, postage, collection agency fees, billing agency fees, or fees resulting from my account becoming delinquent incurred by the Pediatric Associates of Avon or their employees for service provided which might be incurred as a result of my not providing the Pediatric Associate of Avon with my most current or most up to date insurance information. I agree to provide the office of the Pediatric Associates of Avon any and all documentation issues which might affect payment to the office, such as divorce settlements, bankruptcy, or other legally imposed wage garnishments or payment arrangements and I am responsible for all services and debts incurred prior to this documentation being provided. I agree to pay any penalty (collection fee, interest, postage, etc.) incurred from or associated with unpaid balances.

3. Notice of right to request a good faith estimate.

A. Indiana law requires our office to provide notice to patients of their right to request a good faith estimate of anticipated charges for a scheduled, nonemergency service. The law requires our office to provide the good faith estimate within five (5) business days of receiving the patient's request.

B. Our office has elected to provide this patient rights notice to patients who make financial services or billing department inquiries. When a patient makes a financial services or billing department inquiry, staff shall give notice to such patient through the following means:

(1). When a patient appears in-person to make the inquiry, provide the patient with a written copy of the notice at the conclusion of the patient's visit.

(2). When a patient makes the inquiry through a telephone call, direct the patient to our website to learn more about requesting a good faith estimate. Our office has elected not to include information about good faith estimates during on-hold messaging.

(3). When a patient makes an email inquiry, the response email should include a link to our website to learn more about requesting a good faith estimate.

C. You may contact the office manager to find copies of the written notice or if you have questions about the location of the internet notice.

4. Out of Network Covered Health Services - I acknowledge and understand that, during my course of treatment, Physicians may refer me for health care items or services to one or more healthcare providers who are considered "out of network" with my health insurance plan or not associated with the Practice, and such out of network providers are not bound by the payment provisions of my health insurance plan that apply to health care items or services rendered by an in-network provider. I understand that, prior to receiving any health care items or services from an out of network healthcare provider, I may contact my health insurance company for assistance and request a list of in-network providers that may render the referred health care items or services.

5. **Authorization to Leave Message –** With my consent, Pediatric Associates of Avon may call my home or other designated location and leave a message on voice mail , text message or email in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any information pertaining to clinical care (including laboratory and radiology results).

6. **Authorization to Mail Information** – With my consent, Pediatric Associates of Avon may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

7. Authorization to E-Mail Information – With my consent, Pediatric Associates of Avon may E-mail to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

8. **Authorization to Display** – With my consent, Pediatric Associates of Avon may display a photograph or other image of my child or children that may be provided by me.

9. **Patient Permission for Physicians to Release Protected Health Information to Third Parties** – By signing below, I permit Pediatric Associates of Avon to disclose certain protected health information (PHI) about my child to the party or parties listed below. I permit Pediatric Associates of Avon to disclose the following individually identifiable health information:

_____ Immunization Records _____ Health or Daycare Forms _____ Sports Forms _____Medication and Nutrition Forms

_____ Other (please specify: ____)

The above information may be released to the following: _____ School (Principal/Nurse/Athletic Director) _____ Daycare Director

_____ State or County Health Department _____ Other (please specify: ________________________________)

When the information is disclosed according to this permission, it may be disclosed by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this permission in writing except to the extent that Pediatric Associates of Avon has already acted in reliance upon this permission.

9. **Acknowledgment of Receipt of Notice of Privacy Practices (Federal HIPAA Privacy Regulations)** – By my signature below, I am acknowledging that the office of PEDIATRIC ASSOCIATES OF AVON, P.C. has provided me with a copy of their Notice of Privacy Practices.

Child's Name: ____ DOB: ____________________

Signature of Parent or Legal Guardian	**Date**	**Printed Name of Parent or Legal Guardian**