

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. Vandana Patel, Dr. James Shmallo &/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. Patel &/or Dr. Shmallo. 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 valid insurance information and to pay any copays and/or balances due before any service is rendered by the physicians, nurses or employees of Pediatric Associates of Avon. **In the event that my insurance provider denies coverage for any services rendered by Pediatric Associates of Avon due to my failure to cooperate, provide necessary information, or otherwise adhere to the insurer's requirements, payment for such services will be deemed as amounts owed by me and I will be personally responsible for the full payment of the denied charges.** I hereby agree to pay any & all office fees or charges not covered by my insurance company or relating to amounts deemed to be owed by me under this section. 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 that Pediatric Associates of Avon or its representatives incur as a result of my not providing Pediatric Associates of Avon with my most current or most up to date insurance information. I agree to provide the office of Pediatric Associates of Avon with any and all documentation of 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. No Show Policy – A "no-show" or late cancellation occurs when you miss an appointment or cancel with less than 24 hours' notice. A \$50 fee will be charged to your account for any late cancellations or no-show appointments. Exceptions may be made at the practice's discretion for emergencies. Please note that insurance companies do not cover missed appointment fees, so you are personally responsible for the \$50 charge.

5. 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.

6. Authorization to Electronic Communications – With my consent, Pediatric Associates of Avon or its representative may use any of the following means to communicate with me regarding my treatment, payment, and healthcare operations, including to send appointment reminders, provide information pertaining to clinical care (including laboratory and radiology results), send patient statements, or to communicate payment or insurance items: (1) Phone, voicemail, or text message; (2) Email; (3) Mail. In accordance with the Telephone Consumer Protection Act (TCPA), this consent means that you have "opted in" to receive automated communications on your mobile device(s). Please note that you can revoke consent to receive these messages at any time by contacting Pediatric Associates of Avon.

7. 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.

8. 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 HIPAA 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.

10. 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.

11. Health Information – Families may gain access to their health information by filling out the "Request for Release of Medical Records". This can be turned into our office, and a complete copy of the health information can be obtained. A fee will be applied. The complete copy of the health information will be available 15 days (with a possible 15 day extension) after the request is processed.

Child's Name: _____ **DOB:** _____

Signature of Parent or Legal Guardian

Date

Printed Name of Parent or Legal Guardian