

ALTA LOMA PEDIATRICS

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CONSENT TO TREAT A MINOR/CHILD

Today's Date: ____ / ____ / ____

Patient's/Child's Name: _____ Date of Birth ____ / ____ / ____
Last. First. M.I.

I, _____, the parent/legal guardian of the child/minor named in this document, give the permission to the health care provider to administer such examination, treatment, testing, vaccinations, medical plan and procedures as are deemed necessary in the course of the child/minor care.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (HIPPA):

I understand and have been provided with a notice of privacy practices (privacy notice), which provides a more complete description of information and disclosures. I understand that I have a right to review the notice before signing it. I understand that I have the right to revoke this consent in writing, except to the extent that the healthcare provider has already taken action on my behalf.

I, the parent/legal guardian of the patient named in this document, have received a copy of this office's Notice of Privacy Practice.

SUBMISSION OF VACCINES INFO TO CA IMMUNIZATION REGISTRY (CAIR)

I, the parent/legal guardian of this patient give permission to Alta Loma Pediatrics to submit vaccines records to CA Registry (CAIR).

FINANCIAL RESPONSIBILITY:

Information about me necessary to substantiate my insurance claims may be used by the healthcare provider involved in my care. I hereby authorize any insurance carrier with whom I have a policy to pay directly to the healthcare provider any benefits of any policies of insurances to the healthcare provider who has rendered the service to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the healthcare provider are not paid after reasonable notice, that account shall be deemed delinquent and a service charge fees shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for the collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amount in default.

OFFICE FINANCIAL POLICY:

- ❖ **PAYMENTS/CO-PAYS:** The patient is expected to present an insurance card at each visit. All co-payments, deductibles, co-insurance and past due balances are due and payable at the time of service. The patient/parent is expected to inform the office with any change of health plan/insurance or contact information at each visit.
- ❖ **SELF-PAY ACCOUNTS:** Self-pay accounts are patients covered by insurance plans in which the provider does not participate, patients without an insurance card on file, or patients who do not have any insurance coverage. The parents shall pay in full at the time of service.
- ❖ **NON-PARTICIPATING INSURANCE PLANS:** we will file to these insurance plans as a non-assigned claim as a courtesy to our patients. The parents shall pay in full at the time of service. The insurance company may or may not reimburse the parent on non-assigned claims.
- ❖ **PATIENT REFUNDS:** The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family's account, and there are no outstanding patient balances on the family's account.
- ❖ **CHILD CUSTODY CASES:** The custodial parent is responsible for co-payments at the time of service for participating instances and for all past due balances. If the non-custodial parent carries the insurance, the office will bill that insurance company. It is the parents' obligation to work out an agreement and insure payment to our office.
- ❖ **AFTER HOURS:** a fee may apply to any medical services rendered after hours including medical consult over the phone.
- ❖ **CHECKS:** we do NOT accept checks.
- ❖ **FORMS FEE:** a fee may be applied for School physical forms / sport physical forms / special letter/ vaccines records/ and medical records.

MISSING APPOINTMENT: \$25.00 fee may be applied for missed appointment, unless canceled or rescheduled 24 hours in advance.

By signing this document, I agree/ give permission on all items listed in this document.

Name: _____

Relationship To Patient (Circle one): Mother , Father , Foster Parent , Legal Guardian , Other: _____

Signature _____

Witness (Name and Signature) _____ Title _____ Date _____