Cottonwood Pediatrics
700 Medical Center Dr, Ste 150
Newton KS 67114
Phone: 316-283-7100
Fax: 316-283-7118

Consent to Treat, Assignment of Benefits and Financial Policy

Consent to Treat: By signing, you consent to treatment in our office at today's visit. This includes any examinations, tests, immunizations, or other procedures which may be deemed advisable or necessary. You will be notified of any such testing and you have the right to an explanation of any procedures and their risks, benefits, alternatives, and charges before they occur. Your signature here consents to these procedures; it is your responsibility to inquire about and/or decline any such procedures. The occurrence of a procedure indicates that you understand the risks and benefits and have received a satisfactory response to your questions, if any.

Insurance: if the patient is covered by an insurance plan with which we contract, we will adhere to the terms of that contract and will file your insurance claim for you. By signing below, you allow us to file this claim for you and assign all insurance benefits arising from the claim to be paid directly to our office. You also accept responsibility for any charges not covered by your insurance plan and which are legally billable to the insured; you accept full responsibility if your insurance is terminated or otherwise invalid. You also grant us permission to file an appeal on your behalf (in accordance with applicable law) if the insurance company denies or restricts payment. If the patient is covered by a plan with which we do not participate, we will provide you with the necessary documentation to file your own claim for reimbursement, and you will be fully responsible for the appropriate charges for today's care.

If your plan requires any authorization (prior or otherwise) for any service, whether at our office or elsewhere, we will assist you as possible, but be aware that the responsibility for such authorization lies with you.

Financial Policy: Thank you for choosing Cottonwood Pediatrics as your child's healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment.

Payments: All applicable co-pays, personal balances, both current and prior, are due at time of service. We accept cash, check or credit cards.

Usual and Customary Rates: We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining. **You will be financially responsible for any non-covered services, Medicaid or otherwise, performed on your child's behalf by any staff at this office.**

Missed Appointments: If you miss 3 appointments without canceling at least 24 hours in advance, you will need to switch your child's care to another primary care physician, and we will no longer make appointments for you at Cottonwood Pediatrics.

Past Due Accounts: Overdue accounts will be referred to a collection agency. Legal and/or collection fees that we pay to secure past due balances will be added to your account.

Co-Pay Balances: Payment for co-pays are expected at time of service. If co-pay balances are not paid on date of service, an amount equal to 50% of your co-pay will be added to cover our billing costs. This fee is not covered by insurance so it will be your personal responsibility.

Returned Checks: For checks returned to us as unpaid by your bank, we will charge a $30.00 fee.

We reserve the right to dismiss any patient from our practice, if the patient (or patient's parent/guardian):

- Refuses to actively and appropriately participate in their own (or their child's) medical care
- Abuses our staff
- Disrupts our office functions
- Refuses to pay copays, co-insurance, provide insurance information, provide information to their insurance

These are merely examples of behaviors that warrant dismissal from our practice. Each situation is evaluated on an individual basis and reviewed by a dismissal committee.

Please contact our Billing Office if you have any questions or concerns at (316) 283-7100.

I have read the above statements and accept full responsibility for the listed items.

Date	Signature of Patient or Legally Responsible Party	Relationship to Patient

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Patient Privacy Notice

In accordance with Federal Privacy Law (Health Insurance Portability and Accountability Act, HIPAA), Cottonwood Pediatrics keeps medical information and records confidential, and will only use them for patient treatment, health care operations, billing purposes and research.

TREATMENT:	Our pediatricians, clinicians, nurses and staff will use your child's medical information to give him/her the best possible care.
HEALTH CARE OPERATION:	Cottonwood Pediatrics will use this information for appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.
BILLING PURPOSES:	Cottonwood Pediatrics will use your child's medical information to bill the appropriate third party(ies) for your child's care. **You may choose to not have us bill your insurance carrier, *but only if you are paying costs in full on the date of service.*** The Cash Pay Request Agreement must be completed. If you choose this option, your child's medical information will not be disclosed to your insurance carrier or health plan.
RESEARCH:	Cottonwood Pediatrics may use your child's medical information for research purposes in coordination with Heartland Research. As a business associate of Cottonwood Pediatrics, Heartland Research has signed a contract which states that they will appropriately safeguard your personal information.

We are legally required to tell you that your child's personal health information cannot be sold by anyone without your express written authorization, and only after disclosure by the seller of the purpose of sale. However, **Cottonwood Pediatrics <u>does not</u> sell any of this information,** and never has.

Disclosure of Information with Extenuating Circumstances

1. Health information will be given to family members in case of an emergency or under other circumstances with proper authorization and documentation.
2. Health information may be given to other physicians or institutions under emergency situations.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is served on this office, or by order of the Court.

If you have any questions or concerns about this privacy policy, you may ask to speak to the Cottonwood Pediatrics Privacy Officer, at 316-283-3627. In the event of a breach of security, those parents whose children's private health information may have been compromised will be notified.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the medical/financial information we already have. Parents will be notified if any significant changes are made. You may ask for a copy of this privacy notice from any clerical employee at any time.

I hereby acknowledge I was offered a copy of this Notice and either declined or received a copy of such Notice.

Parent or Guardian	On behalf of (Patient's name)	Date

Effective 3/26/13

New Patient Information

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Patient Information

Patient Name _____ DOB _____

Address (street)_____ (mailing address, if different)_____

City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ SS # _____

Race _____ Ethnic group _____ Preferred language _____

I decline to state my/my child's race, ethnic group or primary language _____ (Please Initial)

Primary Insurance Information

Insurance Company Name _____

Policy/ID # _____ Group # _____

Policyholder name _____

Policyholder's DOB _____ Policyholder's SSN _____

Policyholder's relationship to patient:
- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other _____

Policyholder's address (street, city, state, zip) _____

Policyholder's home phone _____ Other phone _____

Policyholder's employment _____

Room for additional insurance information on back – please provide complete information for all insurance policies covering the patient

Please present your insurance card(s) or a copy of your insurance card(s) at check in

Parents Information ***required information**

***Mother's Name** _____ ***Email** _____

Please fill out the following if not given above (or on the back) with insurance information:

Address (street, city, state, zip) _____ DOB _____

Home Phone _____ Other phone _____ SSN _____

Place of employment _____

***Father's Name** _____ ***Email** _____

Please fill out the following if not given above (or on the back) with insurance information:

Address (street, city, state, zip) _____ DOB _____

Home Phone _____ Other phone _____ SSN _____

Place of employment _____

Additional Insurance Coverage Information

Insurance Company Name _____

Policy/ID # _____ Group # _____

Policyholder name _____

Policyholder's DOB _____ Policyholder's SSN _____

Policyholder's relationship to patient:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other _____

Policyholder's address (street, city, state, zip) _____

Policyholder's home phone _____ Other phone _____

Policyholder's employment _____

Additional Insurance Coverage Information

Insurance Company Name _____

Policy/ID # _____ Group # _____

Policyholder name _____

Policyholder's DOB _____ Policyholder's SSN _____

Policyholder's relationship to patient:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other _____

Policyholder's address (street, city, state, zip) _____

Policyholder's home phone _____ Other phone _____

Policyholder's employment _____

This form is not required, however, it MUST be completed if your child comes to his/her appointment with a caregiver.

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www.cottonwoodpeds.com

Consent to Treat

(For caregivers of minor children when a parent is not present)

TO AVOID DELAYS IN TREATMENT
Please return this completed form by mail to the address above,
or by fax to 316-283-7118,
BEFORE the child's appointment

When I/We are not present, the undersigned parent(s) or legal guardian of the child listed below:

_____ _____
Child's name Date of Birth

authorize: _____ who is _____ to the child
Name of adult who is a caregiver of this child (grandparent, aunt, etc.)

and a caregiver of this child, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, immunizations, injections or treatment; and/or hospital care to be provided to said child, when such services are recommended and supervised by Cottonwood Pediatrics. I/We authorize Cottonwood Pediatrics to call in, at their discretion, any necessary consultants.

I understand that, despite this consent, Cottonwood Pediatrics, in its sole discretion, **may decide not to act on this consent**, and instead require my presence during my child's treatment or care.

I also understand that **I am financially responsible for any co-pays and charges** not covered by my insurance which are incurred as a result of this consent for treatment and care.

Unless it is revoked sooner in writing, this consent remains in effect until my child is
☐ 18 years old ☐ until the _____ of _____, 20 ___.

_____ _____
Father's signature AND/*OR* Mother's signature

_____ _____
Date *OR* Legal Guardian's signature

Parent / guardian's
home address: _____ Phone: _____
Parent / guardian's
employment: _____ Phone: _____

Other phone number(s) at which parent or guardian can be reached: _____

Child's known allergies: _____

Other significant health problems: _____

Date of child's most recent tetanus shot: _____

Medications currently being given to child: _____

I agree to see to, and may consent to, the above-named child's medical care, as provided on this form.

_____ _____ _____
Caregiver's signature Date Caregiver's address and phone

This form is not required; however, you MUST fill it out if your child has previously seen another health care provider, in order to transfer medical records.

Authorization for Release of Patient Health Information and Records

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Patient's Name _____ _____
LAST FIRST MIDDLE INITIAL PATIENT'S DATE OF BIRTH

Patient's Social Security # _____ Phone # of patient over 18 _____
This number is ☐ My cell ☐ My parent's phone number

Parent's Name _____ _____
LAST FIRST MIDDLE INITIAL DAYTIME PHONE NUMBER

I authorize the following organization to release information as stated below from the patient health information record. This authorization is effective for one year beginning: _____(today's date) and ending _____(one year from today).

INFORMATION TO BE RELEASED *FROM*:	**INFORMATION TO BE RELEASED *TO*:**
☐ Cottonwood Pediatrics ***OR***	☐ Cottonwood Pediatrics ***OR***
☐ _____ Organization/Person Name	☐ _____ Organization/Person Name
_____ Street Address	_____ Street Address
_____ City, State, Zip	_____ City, State, Zip
_____ Telephone Number	_____ Telephone Number

TYPE OF RECORDS REQUESTED (Charges for copies of records may be associated with your request)

- ☐ Health care information related to the following treatment or condition: _____
- ☐ Laboratory/Diagnostic Tests: _____
- ☐ All records, **including growth charts & immunization records**, and any records in these subject areas:
  - ☐ Sexually Transmitted Diseases (includes HIV/Aids) ☐ Drug/Alcohol Abuse Treatment ☐ Mental Illness
- ☐ Other (specify): _____

Purpose or Need for this Information: ☐ Continuing care ☐ Copies for own use
☐ Transfer – age 18 ☐ Transfer – moving ☐ Transfer – other
☐ Other _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Cottonwood Pediatrics Medical Records Release of Information office at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days from the date below. A fee may be charged for preparing, copying and sending records.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

_____ _____ _____
Date Signature of Patient or Legally Responsible Party Relationship to Patient