Gwendolyn Delaney, MD Soraya Lim, MD Belinda Miller Topa, MD Gargi Shikhare,MD

New Patient/ Newborn Waiver

I state that I have not yet provided Vickery Pediatrics with my child's, _____, completed medical insurance information. I acknowledge
(Child's Name)
that no coverage is bound until which time that I have provided Vickery Pediatrics with the necessary insurance information for my child.

I understand that all balances must be paid in full within one month **(30 day).** Further, I understand that my signature on this form establishes _____ as financially responsible for all patient balances.
(Guarantor of Insurance)

This waiver states, therein, the signer accepts full assumption of financial responsibility for any and all unpaid charges after the one month **(30 day)** period has elapsed. After which, the patient is considered a Self-Pay patient.

Our office does NOT accept Peach State, Kaiser, Ambetter or WellCare insurances.
We do accept straight Medicaid, Amerigroup and Care Source insurances.

Signature: _____ Date: _____
(Parent/Guardian)

New Patient Information

How did you hear about us? (Please check one) ☐ Friend ☐ Physician ☐ Yellow Pages ☐ Website ☐ Insurance Co. ☐ other_____

PATIENT INFORMATION					
Patient Name:		DOB		Today's Date	
Web- enable me for access to patient portal	Yes	No	Enable me for electronic statements to be sent to my patient portal	Yes	No
Address:					
City		State		Zip code	
Email address:					

CONTACT INFORMATION					
Father's Name:			**Mother's Name**:		
Social Security #:			Social Security #:		
DOB			DOB		
Cell phone:			Cell phone:		
Alternative Phone:			Alternative Phone:		
Work Phone			Work Phone:		
Address (if different from above):			Address (if different from above):		
City	State	Zip code	City	State	Zip code
Name of Emergency Contact:	Relation to patient:		Phone:	Address:	

INSURANCE		
Primary Insurance Company name:	Subscriber #:	Group #:
Guarantor	Provider services #:	
Secondary Insurance Company Name	Subscriber #:	Group #:

I authorize the release of any medical or other information necessary to process my child(ren)'s insurance claim. This includes the release of medical information to other physicians or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to Vickery Pediatrics, LLC for services rendered. All Payments are requires on the date of service. We ask for 24 hour notice to cancel an appointment with our providers.

PLEASE NOTE: Insurance card(s) and co-pay amounts (if applicable) MUST be presented at EACH visit otherwise services may not be rendered.

Authorized by: _____ (Parent/Legal Guardian) Date: _____

PHARMACY			
Name:	Address:	Phone:	Fax:

Authorization for Access to Protected Health Information and Medical Treatment of My Minor Child

For Divorced or Separated Parents: Each parent has equal access to health information about their unemancipated child and equal medical decision making for all treatments and services unless there is a court order to the contrary that is known us, where parental rights are restricted. A **copy of the court order is required** to be kept on file in your child permanent medical record(s).

Please indicate below those individuals with who there is restricted access:
Name_____ **Relationship**_____
Name_____ **Relationship**_____

Permission to treat Minors without a parent or legal Guardian Present: Vickery Pediatrics must receive permission from a child's parent or legal guardian prior to providing treatment(s) for preventative care, injury, or illness that is non-life threatening. This form provides the legal permission to either (depending on the minor's age) treat without any adult present (Section A), or with a designated adult present (Section B). **Note: A parent or legal guardian MUST BE present for a minor's first visit with Vickery Pediatrics.**

Section A: Authorization for a minor child, between the ages of 16 to 18 years of age, to receive medical services WITHOUT a parent or guardian present.

I, _____, the parent/legal guardian of (Child) _____, born __/__/20__, do hereby consent to any medical care, laboratory services, and administration of medications or vaccinations, by a physician at Vickery Pediatrics, which is deemed medically necessary for the welfare of my child, while I am unavailable either in person or by phone. I also agree to be financially responsible for payment of all charges in connection with the care and treatment(s) rendered.

This authorization is effective from today until ___/___/20___.

Signed_____ Date_____ Phone #_____

Section B: Authorization for a minor child, less than 18 years of age, to receive medical services with an alternative adult, other than a parent or guardian present.

I, _____, the parent/legal guardian of (Child) _____, born __/__/20__, do hereby consent to any medical care, laboratory services, and administration of medications or vaccinations, by a physician at Vickery Pediatrics, which is deemed medically necessary for the welfare of my child, while in the care of the following individual(s) (See Below), while I am unavailable either in person or by phone. I also agree to be financially responsible for payment of all charges in connection with the care and treatment(s) rendered.

Name_____Relationship to Minor_____
Name_____Relationship to Minor_____
Name_____Relationship to Minor_____

This authorization is effective from today until ___/___/20___.

Signed_____ Date_____ Phone #_____

PATIENT INITIAL HISTORY QUESTIONNAIRE

VICKERY PEDIATRICS

_____ _____ _____ ☐ Male ☐ Female

NAME DATE BIRTHDATE

Separate form must be completed for each child

Household

Please list all those living in the child's home.

Name	Relationship to child	Birthdate	Health Problems?

Are there step-siblings or half- siblings not listed? If so, please list their names, ages, and where they live _____

_____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parent's ☐ Joint Custody ☐ Single Custody
☐ Lives with foster family ☐ Lives with grandparents/other guardian
If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History ☐ Unknown birth history

1. Birth weight _____ was the baby born at term? _____ OR _____ weeks
2. Were there any prenatal or neonatal complications? ☐ Yes ☐ No
   Explain _____
3. Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____
   ☐ was the infant in breech position at the time of delivery?
4. Did baby go home with mother? ☐ Yes ☐ No
   Explain _____
5. Was a NICU stay required? ☐ Yes ☐ No
   Explain _____
6. During pregnancy, did mother: Use tobacco ☐ Yes ☐ No : Drink alcohol ☐ Yes ☐ No : Use any illicit drugs/substances ☐ Yes ☐ No
   other_____
7. Use medications ☐ Yes ☐ No Use prenatal vitamins ☐ Yes ☐ No what? _____ when?_____

General U= unknown

1. Do you consider your child to be in good health? ☐ Yes ☐ No ☐ U Explain
_____
2. Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ U Explain
_____
_____
3. Has your child had any surgery? ☐ Yes ☐ No ☐ U Explain
_____
4. Has your child ever been hospitalized? ☐ Yes ☐ No ☐ U Explain
_____
5. Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ U Explain
_____
6. Are you concerned about having enough to eat/ having safe, affordable housing/ about providing for adequate education? ☐ Yes ☐ No ☐ U
Explain _____

Biological Family History U = Unknown

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ U	Who_____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ U	Who_____	Comment_____
Asthma	☐ Yes	☐ No	☐ U	Who_____	Comments_____
Tuberculosis	☐ Yes	☐ No	☐ U	Who_____	Comments_____
Heart disease (before 55 yrs. old)	☐ Yes	☐ No	☐ U	Who_____	Comments_____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ U	Who_____	Comments_____
Anemia or bleeding disorder	☐ Yes	☐ No	☐ U	Who_____	Comments_____
Dental decay	☐ Yes	☐ No	☐ U	Who_____	Comments _____
Cancer (before 55 yrs. old)	☐ Yes	☐ No	☐ U	Who_____	Comments_____
Liver disease	☐ Yes	☐ No	☐ U	Who_____	Comments_____

Diabetes (before 55 years old)	☐ Yes	☐ No	☐ U	**Who**_____	**Comments**_____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ U	**Who**_____	**Comment**_____
Obesity	☐ Yes	☐ No	☐ U	**Who**_____	**Comments**_____
Epilepsy or convulsions	☐ Yes	☐ No	☐ U	**Who**_____	**Comments**_____
Alcohol or drug abuse	☐ Yes	☐ No	☐ U	**Who**_____	**Comments**_____
Mental illness/depression	☐ Yes	☐ No	☐ U	**Who**_____	**Comments**_____
Developmental disability	☐ Yes	☐ No	☐ U	**Who**_____	**Comments** _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ U	**Who**_____	**Comments** _____
Tobacco/ vaping /marijuana use	☐ Yes	☐ No	☐ U	**Who**_____	**Comments**_____

Additional family history _____

Patient (child's) Past Medical History **U = Unknown**

Chickenpox	☐ Yes ☐ No ☐ U	**When**_____
Frequent ear infections	☐ Yes ☐ No ☐ U	**Explain** _____
Hearing loss	☐ Yes ☐ No ☐ U	**Explain** _____
Nasal allergies	☐ Yes ☐ No ☐ U	**Explain** _____
Problems with eyes or vision/ Wears glasses/contacts	☐ Yes ☐ No ☐ U	**Explain** _____
Asthma, bronchitis, bronchiolitis, or recurrent pneumonia	☐ Yes ☐ No ☐ U	**Explain** _____
Any heart problem or heart murmur	☐ Yes ☐ No ☐ U	**Explain** _____
Anemia or bleeding problem	☐ Yes ☐ No ☐ U	**Explain** _____
Blood transfusion	☐ Yes ☐ No ☐ U	**Explain** _____
HIV	☐ Yes ☐ No ☐ U	**Explain** _____
Organ transplant	☐ Yes ☐ No ☐ U	**Explain** _____
Cancer/bone marrow transplant/chemotherapy	☐ Yes ☐ No ☐ U	**Explain** _____
Crohn's/UC/Celiac disease	☐ Yes ☐ No ☐ U	**Explain** _____
Frequent abdominal pain/IBS	☐ Yes ☐ No ☐ U	**Explain** _____
Constipation requiring doctor visits	☐ Yes ☐ No ☐ U	**Explain** _____
Recurrent UTI/ Kidney disease/ urologic malformations problems	☐ Yes ☐ No ☐ U	**Explain**_____
Metabolic/genetic disorders	☐ Yes ☐ No ☐ U	**Explain** _____
Food allergies	☐ Yes ☐ No ☐ U	**Explain**_____
Bed-wetting (after 5 years old)	☐ Yes ☐ No ☐ U	**Explain** _____
Sleep problems; snoring	☐ Yes ☐ No ☐ U	**Explain** _____
Chronic or recurrent skin problems (eczema, acne)	☐ Yes ☐ No ☐ U	**Explain** _____
Frequent headaches	☐ Yes ☐ No ☐ U	**Explain** _____
Convulsions/concussions/ other neurological problems	☐ Yes ☐ No ☐ U	**Explain**_____
Obesity	☐ Yes ☐ No ☐ U	**Explain**_____
Diabetes	☐ Yes ☐ No ☐ U	**Explain** _____
Thyroid or other endocrine problems	☐ Yes ☐ No ☐ U	**Explain** _____
High blood pressure	☐ Yes ☐ No ☐ U	**Explain** _____
History of serious injuries/fractures	☐ Yes ☐ No ☐ U	**Explain** _____
Use of alcohol or drugs	☐ Yes ☐ No ☐ U	**Explain** _____
Tobacco use/ vaping/marijuana	☐ Yes ☐ No ☐ U	**Explain** _____
ADHD/anxiety/mood problems/depression	☐ Yes ☐ No ☐ U	**Explain**_____
Developmental delay	☐ Yes ☐ No ☐ U	**Explain** _____
Dental decay	☐ Yes ☐ No ☐ U	**Explain** _____
History of family violence	☐ Yes ☐ No ☐ U	**Explain** _____
Sexually transmitted infections	☐ Yes ☐ No ☐ U	**Explain** _____
Pregnancy	☐ Yes ☐ No ☐ U	**Explain** _____
For girls, problems with her periods	☐ Yes ☐ No ☐ U	**Explain** _____

Does your child have, or has your child ever had:

Has had first period ☐ Yes ☐ No **Age of first period** _____ **Any other significant problem(s)** _____

Vickery Pediatrics @ the Collection – Forsyth

410 Peachtree Parkway, Suite 4260 | Cumming, GA 30041 | Phone: 678-990-2501 Fax: 678-990-2505

www.vickerypediatrics.com | Follow Us on FACEBOOK & INSTAGRAM

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678-990-2505 (F)
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Authorization for Release of Medical Information

Patients Name_____Date of Birth _____

Address_____City_____State_____Zip Code_____

Phone Number_____Date of Request_____

I authorize Vickery Pediatrics, LLC

TO RELEASE INFORMATION TO:

_____
Name of Provider or Facility Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

I authorize Vickery Pediatrics, LLC

TO OBTAIN INFORMATION FROM:

_____
Name of Provider or Facility Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐

TYPE OF RECORDS REQUESTED (check one)

☐ Immunization History ☐ Medical Summary
☐ Complete medical record (Burned onto a disc; includes all visit notes, labs, immunizations, growth chart)
☐ Specific Treatment (select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Physical Therapy ☐ X-Ray Reports ☐ Lab Results

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.
☐ One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I UNDERSTAND THAT:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of Patient or Representative_____Date_____

Relationship to Patient (If requester is not the patient) _____

Vickery Pediatrics, LLC

Thank you for choosing Vickery Pediatrics as your child's healthcare provider. Our office strives to provide the highest quality healthcare. Our office is committed to assisting you with insurance filing and payment of your account. In order to accomplish this, we have created the following financial policy.

Please Read Entire Policy Carefully

You must have a Valid ID, Insurance Card and ability to pay any previous balances, current co-pays and/or co-insurance at time of visit in order to be seen.

Appointment scheduling

To be certain we schedule your appointment correctly, we will be asking questions about your child's illness in order to ensure that we have given enough time for the doctor to address all your concerns. Please let us know in advance if you have any time constraints, as emergencies can occur and may cause delays in the schedule.

Annual Preventative (Well Child) Visits or Sport's Physicals should be scheduled at least 4-6 weeks in advance. After the age of 3 years, most insurance companies will only allow on visit per year. Depending on the company, this "year" may run **365 + 1 day** from the date of the child's last Annual Preventative exam or may allow for one Annual Preventative exam per each "calendar year". When checking insurance eligibility, we cannot always see what your insurance allows. It is your responsibility to understand the rules/restrictions/limitations of your insurance policy. **We do not accept financial responsibility for parents' or guardians' lack of knowledge as to the limitations and/or restrictions of their individual insurance policies.**

Timely Arrival

Missed appointments represent a cost to you and us, as well as to other patients who could have been seen during that time set aside for your child. For this reason, we do not allow for more than two appointments per family to be booked back-to-back in advance.

So please call at least 24 hrs before your scheduled visit time, to reschedule or cancel, in order to prevent a charge of **$75 for a No Show fee**. No Show fees are not covered by your insurance provider and will be charged to you.

Late Arrivals are considered to be when a patient arrives **15 minutes past their scheduled visit time** and will be treated as a No Show.

If you are running late, please call. If we are able to move your appointment to later in the day or rebook your time spot, you can avoid the $75 No Show Fee.

Rescheduled appointments due to failure to have a valid insurance card or inability to pay previous balance or co-pay/co-insurance upon arrival for your scheduled visit, may be assessed a $75 No Show fee.

Divorce

In the case of divorced or separated parents, it is our office policy that the parent who brings the patient to the office is responsible for any payments due at the time of service. We will not bill the non-presenting parent.

Responsibility for Medical Care

Every Minor Child (under age 16 yr.) seen in our office for medical services **MUST** be accompanied by a parent, legal guardian or by an adult who has obtained written consent for treatment from the parent or legal guardian. We must have a copy of such agreement on file or it must be presented at the time of the visit.

Any Child 18 -21 yr. of age that presents alone, must have a valid insurance card, photo ID and payment for outstanding balances/co-pay or co-insurances at the time of visit.

Walk-in Policy

We are a "***by-appointment only*** "office. If available, we will make every attempt to get you an appointment later the same day.

After Hours Care

We contract with CHOA's Nurse Advice Line to provide guidance/counseling after normal office hours. One of our providers is on back up and may be paged by the nurse, if needed. We pay to provide this service for you. **So, please send all non-**urgent questions/concerns through the secure patient portal to be addressed during regular office hours.

Excess abuse of the CHOA Nurse Advice Line may result in the fees being billed to you.

Prescription Refills

Medication refills will only be done during regular office hours when your child's records are available. **We do not call in antibiotics over the phone**.

Forms and Letter Requests

At some point you will likely require a form to be completed for your child. We request that you bring these forms to your child's annual preventative (well child) visit, and we will be happy to complete them **free of charge,** with the exception of the certain states funding application forms**.

However, any form submitted at other visits/times or sibling forms (*if requested on a date other than their annual preventative visit*) will require a payment of **$10 per form**. Payment is required in advance of preparation of the requested form or letter. **This fee will not be billed to insurance.**

Please allow us 3-5 business days to complete. Once completed, we can have the forms available for pick-up at the office, return by secure email or by fax.

The following are examples of such forms:

FMLA, Camp forms, Insurance forms (prior authorization or other), Travel forms, Forms for Daycare/School/College (such as: Admission, Sports participation forms, Immunization (form 3231), Hearing/vision (form 3300), 504 plans, Asthma/Allergy/Seizure action plans, School Medication forms and Hardship transfers).

The following are examples of such letters:

School requests such as special diets, extra school books for home use, etc., **Daycare requests** such as special diet or care instructions, **Special needs placement, Appeals/medical necessity letters for insurance companies, Travel-related issues, Adoption, Recommendations for private school admission, Complicated insurance claim justifications**,

** All State/Federal Forms **(TEFRA, Disability, Social Security, Katie Beckett, etc**.) will incur a charge of **$100 for initial filing and $25 for renewals or reprocessing of denials**.

This is due to the complicated nature of these forms and the time intensive nature of the extensive supporting documents that are required.

Requests for Pick-up of Prescriptions

Please allow us 3-5 business days to complete. Once completed, we can have the Prescriptions available for pick-up at the office during normal office hours. If the prescription is for a controlled substance, the parent or guardian will be required to show a picture ID and sign for receipt of the prescription.

Transfer of Records Request

A copy of your child's records can be requested with a signed authorization form. **This is free, if the records are put on to a CD and picked up at our office.** If full paper charts are requested there will be a $25 fee per child. If postage is required for CD/Paper Copies, there will be an additional $10 fee.

Referrals and Prior Authorizations

Except in true medical emergencies, five (5) business days must be given to our office to complete routine referral or prior authorizations. **Self-referrals** will be considered as out of network and may result in the financial liability to the patient. **We do not accept responsibility for patient noncompliance with their individual insurance policies.**

Medical Supplies and Procedures

Many insurance carriers have started deferring the costs of numerous office supplies and therapies to patients' responsibility or toward their deductible. Therefore, we recommend that you know the limitations of your plan before being seen. **We do not accept financial responsibility for parents' or guardians' lack of knowledge as to the limitations and/or restrictions of their individual insurance policies.**

These items have included (but are not limited to) medications provided in the office setting, office supplies like splints/straps, bandages or immobilizers, asthma medications/equipment, other respiratory treatments, as well as, other simple procedures like wart freezing, splinter, foreign body removal or cautery of an umbilicus. Recently, it has also included many annual preventative (well child) services including labs, required screening forms and hearing/vision screenings.

Newborns

You must notify your carrier within 30 days of the child's birth. At the initial visit we will require you to sign a financial agreement to cover that 1st visit in case you have failed to meet that deadline. **We do not accept responsibility for patient noncompliance with their individual insurance policies.**

Expanded Office Visits

"Sick" Concerns at the time of an Annual Physical or Nurse Visit: If your child is scheduled for an Annual Preventative (Well Child) visit or for a Nurse Visit (weight check, Vaccine or Lab draw only) visit but is experiencing symptoms that are addressed by the physician (example: visits that requires a new prescription medication, a referral to new specialist or extensive counseling is required) - you will be charged a "sick" office fee, in addition to other expected visit charges. As such, you insurance company may charge you a co-pay/co-insurance or defer charges from part of your visit to your deductible. We have no control over your insurance's billing policy.

If you return for labs, vaccines or hearing/vision screens on a day other than your Annual Preventative (Well Child) visit, you may be charged a co-pay or co-insurance by your insurance company.

Please review your insurance policy fully upon its renewal each year. **We do not accept financial responsibility for parents' or guardians' lack of knowledge as to the limitations and/or restrictions of their individual insurance policies.**

Ear Piercing

This is an elective procedure and the fee will not be billed to insurance. Payment will be due at the time of service.

Outside Billing

LABS: Although most labs are drawn and collected in our office, very few are actually performed here. For those labs, we typically outsource to Quest or LabCorp. It is your responsibility to let us know which one your insurance requires. If you receive a bill from an outside Laboratory, we ask that you contact them to resolve any questions that you have. **We do not take financial responsibility for any outside laboratory costs.**

VACCINES: We currently contract out for our vaccines with **Vaxcare**, a national vaccine supplier. For 95% of the vaccines, they directly bill your insurance company. There are only a few insurance companies (like Tricare) that we partner bill for them. If you receive a bill from Vaxcare, we ask that you contact them directly to resolve any issues. **We do not take any financial responsibility for any vaccine costs that are billed through Vaxcare**.

Uninsured or Under-insured (Vaccines are not covered on your current Insurance Policy) children are eligible for use of stated funded vaccines (VFC). **If you are not insured by Medicaid or State funded CMO, it is your responsibility to notify us if you require the use of VFC vaccines.** VFC vaccines and all associated administration fees are covered for State/Federal funded insurance plans (Medicaid, Amerigroup, and Care source). While VFC vaccines are free, all other uninsured/under-insured children are still responsible for administration fees associated with these vaccines (see same day discount policy for details).

Patients WITHOUT insurance

Patients without insurance or who do not have proof of insurance at time of visit are considered self-pay patients. Please see Vickery Pediatrics' **Same Day Discount policy** for details.

Secondary or Tertiary Insurance Policies

It is your responsibility to notify us at the time of your visit if you have a secondary or tertiary insurance policy that we are to submit a claim. Additionally, you are required to tell us in which order they are to be billed. **Failure to do so will delay payment and may result in your being financially responsible for the entire amount.** We are only obligated to file claims with companies whom we are contracted and/or credentialed. It is a courtesy to file additional claims, if we are not in network with that insurance company.

Patient refunds

Patient refunds will be issued if the following criteria have been met: (1) the patient has been established with Vickery Pediatrics for >/= ninety (90) days, (b) there are no outstanding insurance claims and (c) there are no outstanding balances on the family account.

Vickery Pediatrics, LLC

For Patients with Insurance

We are a provider of medical services. We are not party to the contract made between you and your employer and/or your insurance company. Therefore, we encourage you to contact your carrier personally in order to remain informed of your benefits. **Since insurance plans cannot guarantee all eligibility or benefits, we cannot do so either. In those situations where the services that Vickery Pediatrics provides are not covered by your insurance carrier, payment is expected at the time services are rendered. Cash, checks, credit/debit cards are all acceptable forms of payment. Be advised however, that any returned check for insufficient funds will result in a $50 fee to patient's balance.**

1. You must present your **Child's Insurance card** and a **valid photo ID** at **EVERY visit.**
2. We expect complete and up to date demographic information for us to be able to file a claim on your behalf to the insurance carrier. If this information is incomplete or not updated, you will be responsible for all charges from the visit. If due to inaccurate demographic information we are asked to refile the claim, you may be billed a $25 refiling fee.
3. Copayments, outstanding balances from deductibles and coinsurances are due at the time of service.
4. Any outstanding claim not paid by your insurance company within 60 days of billing will be due to patient responsibility and will be considered past due. You must pay this balance in order to be permitted to schedule non-emergent appointments until the balance is paid.
5. Any Balance over 90 days old will be considered delinquent and be turned over to an outside collection agency. A 30% "collection fee" will be added to the outstanding balance to pay fees from the collection agency and your account will be inactivated. Your child can only be seen for emergent visits for the next 30 days until you have paid the balance of your account. Your account will be considered seriously delinquent at this time and after this 30d grace period, no further appointments will be granted and your child must seek medical care elsewhere.

Self- Pay Patients

We offer a same day discount on all billed services for our patients that are self –pay. Please ask for our same day discount policy for full details. You will still be asked to provide a valid photo ID at every visit and to make sure that demographic information is up to date. If you have insurance coverage at a later date, it is YOUR responsibility to make sure that we have it on file and claims should be filed with them going forward. Payment is expected at the time services are rendered. Cash, checks, credit/debit cards are all acceptable forms of payment. Be advised however, that any returned check for insufficient funds will result in a $50 fee to patient's balance.

I have read the above Financial and Administrative policy for Vickery Pediatrics, LLC and agree with the terms listed.

Parent/Legal Guardian: (Print) _____ (Sign) _____ Date: ___/___/20___

Child 1: (Name) _____ (DOB) _____

Child2: (Name) _____ (DOB) _____

Child 3: (Name) _____ (DOB) _____

Child4: (Name) _____ (DOB) _____

Billing questions or concerns can be directed to admin@vickerypeds.com

Vickery Pediatrics, LLC

HIPAA - Receipt of Notice of Privacy Practices Written Acknowledgement Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved in my treatment).
- Obtaining payment from third party payers (e.g. insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Financial and Administrative Policies

1. You must present your **child's insurance card** and a **valid photo ID** at **EVERY visit.**
2. We expect complete and up-to-date demographic information for us to be able to file the claim on your behalf to the insurance carrier. If this information is incomplete or not updated, we will require payment in full of your charges on the day of the visit. There will be a $10 refiling fee if the correct payment information is not provided at the time of service.
3. Copayments, outstanding balances from deductibles and co-insurances are due at the time of service.
4. A $25 billing fee will be assessed for failure to pay co-pay, co-insurance at the time of service on the 1st occurrence, but no future appointments can be made until that fee and outstanding balance has been paid.
5. Patients with delinquent balances will not be permitted to schedule routine exam appointments until the balance is paid in full.
6. Any outstanding claim not paid by your insurance company within 60 days of billing will be due to patient responsibility and are considered past due.
7. Any balance over 90 days old will be considered delinquent and be turned over to an outside collection agency. A 30% collection fee will be added to the outstanding balance. Your account will be inactivated. Your child can only be seen for emergent visits for the next 30 days until you have paid the balance of your account. Your account will be considered seriously delinquent at this time and after this 30 day grace period, no further appointments will be granted and your child must seek medical care elsewhere.

I have read the above HIPAA, Financial and Administrative policy for Vickery Pediatrics, LLC and agree with the terms listed.

Parent/Legal Guardian:

(Print) _____ (Sign) _____

(Relationship to Patient) _____ (Date) _____

Child 1: (Name) _____ (DOB) _____

Child 2: (Name) _____ (DOB) _____

Child 3: (Name) _____ (DOB) _____

Child 4: (Name) _____ (DOB) _____