Child's Name_____ Date of Birth_____

Focus on Kids Pediatrics Office Policies and Consents

HIPAA Policy

The undersigned patient or legally authorized representative of the patient acknowledges that he or she personally received or was offered a copy of the Focus on Kids Pediatrics Privacy Policy on the date indicated below.

Initial of patient/parent/legal guardian: _____

Consent for Treatment

I voluntarily agree to the tests, procedures and/or treatments which the attending physician has deemed necessary, and which is administered to or performed on my child under the direction of the attending physician and his/her designees.

Initial of patient/parent/legal guardian: _____

Consent to Leave Phone Message

There may be times when a physician or staff member may need to contact YOU with medical information (including but not limited to lab results, referral information and appointment information) via telephone. By filling in the information below you will be allowing us to leave medical information on YOUR answering system at the designated number(s). You may also allow us to leave a message regarding medical information with a designated person (i.e., grandparent or daycare provider, etc.) other than patient, parent or legal guardian (if patient less than 18 years of age) by listing them below. I fully understand that it is my responsibility to notify Focus on Kids Pediatrics of any changes in my contact information and this will remain in effect until revoked in writing.

Name _____ Relationship to Patient_____ Phone Number_____

Name _____ Relationship to Patient_____ Phone Number_____

Initial of patient/parent/legal guardian: _____

Financial Policy

You are responsible for your child's healthcare costs. It is important to become familiar with your specific insurance plan. If you have questions, please contact your insurance company or employer directly. We realize that many families are in a state of change. Divorced, separated, single parent and blended families are common. Please refer to the Divorce Policy for more information on how the office handles these situations. We will bill your insurance company providing we are contracted with them and that you provide us with information at each visit regarding your current plan. Current insurance cards MUST be presented at each visit. Copayments are due on the date services are rendered. Patients with a high deductible insurance plan will be required to pay $50.00 at the time of service. Patients without insurance/"self pay" are required to pay in full at the time of service. All balances over 60 days are considered past due and will be handled appropriately. Payment plans are available through our billing office.

1. I understand that payment for charges are due on the date of service, except for insurance carriers for which Red Rocks Pediatrics is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Red Rocks Pediatrics. I will be responsible for any copayment, deductible or services not covered by my insurance provider. If I do not have insurance coverage for services rendered by Red Rocks Pediatrics, I agree to pay all charges resulting from such services.
3. I hereby authorize Red Rocks Pediatrics to file with my insurance carrier, and I assign payment of medical benefits to Red Rocks Pediatrics.
4. I authorize the release of all medical records and information necessary to process any claim generated by services I receive in this office.
5. I will keep my account current as to charges for which I am responsible. In the event that I fail to pay charges, Red Rocks Pediatrics is entitled to take whatever action necessary to collect such charges, and I will be responsible for reasonable attorney fees and costs incurred because of such collection. I understand that those accounts on a payment plan that are not kept current are subject to further action.
6. I understand that Red Rocks Pediatrics, PC is closed to new patients with state-funded insurance including Medicaid. If it is determined that a family member is found to have coverage, I will be assisted in finding a new medical home for my family that is accepting new patients with state insurance.

Initial of patient/parent/legal guardian: _____

Late and No-Show Policy

In the event you are more than 10 minutes late for your child's appointment, it may be necessary to reschedule your appointment with another provider or at a different time or day. Appointments not cancelled with 24-hour advance notice will have a fee charged directly to the patient. Appointments that are scheduled for the same day and not kept will be charged a no-show fee.

Initial of patient/parent/legal guardian: _____

CONTINUED ON OTHER SIDE →

Child's Name_____ Date of Birth_____

Scheduling Policy

To best provide timely service to our patients, we ask that all visits be pre-scheduled. Walk-in appointments may be turned away depending on office availability. We will do our best to accommodate requested appointment times, but based on provider availability, this may not always be possible.

Initial of patient/parent/legal guardian: _____

Divorce Policy

We believe that divorce, separation, and custody agreements should not enter into a child's medical treatment. The parent who is requesting the medical treatment is individually responsible for the payment of the medical bills. We are not a party to your divorce agreement; we will collect co-pays and deductibles from the ***attending parent.***

"Joint Custody" means that each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results. In the circumstance of joint custody, we will not call the other parent for consent prior to treatment or to inform the non-present parent of the assessment and/or plan of care, if any. Again, we will discuss with the *accompanying parent*, information pertinent to the child's history and/or present exam. It is then the responsibility of the parents to communicate with each other.

We reserve the right to charge an administrative fee for copying records should the requests become excessive. Should issues between the parents become disruptive to our medical practice, we reserve the right to discharge a family from our care and responsibility.

Initial of patient/parent/legal guardian: _____

Respect our Staff

Our providers and staff members make every effort to create a welcoming and comfortable environment for our patients and their parents. We expect ALL members of our care team to treat patients and parents with the utmost compassion and respect. In return, we ask that patients and parents treat ALL members of our care team with respect.

In the event, that any member of our care team feels threatened or disrespected, either in the office or during a phone conversation, it will be brought to the attention of all providers and office management and your family may be dismissed from the practice. In the event that an employee is threatened or physically assaulted, your family will be dismissed from the practice immediately and the authorities will be notified.

Initial of patient/parent/legal guardian: _____

Consent for Use of Health Information Exchange (HIE)

Focus on Kids Pediatrics endorses, supports, and participates in electronic Health Information Exchange (HIE) to improve the quality of your health and healthcare experience. However, you may choose to opt-out of participation in the CORHIO HIE or cancel an opt-out choice at any time.

Initial of patient/parent/legal guardian: _____

Consent to Copy Medical Records

I understand that it may be necessary for other healthcare providers to review information in my child's medical record to render medical care to my child. I authorize Red Rocks Pediatrics to copy part or all my medical record if another healthcare provider needs it to provide medical treatment.

Initial of patient/parent/legal guardian: _____

Consent to E-Mail

I understand that there may be times that the providers and/or staff of Focus on Kids Pediatrics may request e-mailed documentation**. I understand that E-mail communication should NOT be used for general, emergent, or urgent messages as it is not monitored on a daily basis.** I understand that I need to contact the office for appointment requests and medical questions. I understand that electronic communication is not secure.

Initial of patient/parent/legal guardian: _____

My signature indicates that I have read, understand, and agree to ALL terms set above.

Signature of patient/parent/legal guardian_____ Date_____

Printed Name_____ Relation to Patient_____

OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, office consents, and office policies but acknowledgement could not be obtained for the following reason:

_____

Employee Signature _____ Date _____