HEALTHY STEPS PEDIATRICS

Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Healthy Steps Pediatrics as your health care provider. Our fees are based on the cost of delivering quality medical care. We ask that you read the following Financial Policy, initial each section, and sign that you acknowledge and accept our policy.

________ initials **INSURANCE COVERAGE**

You must provide your insurance card or proof of insurance at each visit. If you do not have insurance, are unable to provide proof of insurance, or are on a plan in which we do not participate, you will be considered a self-pay patient. Full payment for self-pay patients is required at the time of service. It is very important that you take an active role in understanding your insurance benefits. Certain plans have restrictions on certain services such as vision/hearing screening, immunizations, and timing of well child exams. It is your responsibility to be aware and understand your plans restrictions and limitations. If you have any questions regarding your coverage, health benefits, health restrictions and payment determination then you need to contact your insurance company directly.

________ initials **PAYMENT METHODS**

Payment for all services, including insurance co-payments and deductibles, are due at the time of service. These fees, by law, cannot be waived. For your convenience, we accept cash, most major credit cards, debit cards and Health Savings Account cards.

________ initials **INSURANCE**

Healthy Steps Pediatrics will bill insurance companies we participate with as providers. You will be responsible for all co-pays and deductibles at the time of service. Some of the services provided may be non-covered services and not paid by your insurance company. You are personally responsible for these services. You will also be responsible for all balances your insurance carrier does not pay within 90 days. You will receive a bill, which must be paid upon receipt. If we are not a provider on your current insurance plan or you do not have proof of insurance, you will be responsible for the entire bill at the time of service. If you have secondary insurance and did not inform us and provide your insurance card, you could be responsible for the entire visit. We can provide you with a detailed receipt of your visit (Superbill), upon request, for you to file with your insurance company.

________ initials **MEDICAL RECORDS & FORMS**

Medical records are the property of Healthy Steps Pediatrics, LLC. You may request copies of medical records by completing a records request form. We will provide copies of required medical records to specialists free of charge. All other copies will be charged per page to cover processing costs, as permitted by law (GA Code § 31-33-3). We will provide you with copies within 30 days of receiving your written request. We provide medical forms 3300, 3231 and Sports Physical forms for services performed during well child visits at the time of service. If you require an additional copy of a form at a later date, or bring in a form for a provider to complete, there will be a $5 charge per form. All form requests require a 72 hour notice for processing.

________ initials **REFERRALS**

If your insurance plan requires a referral prior to seeing a specialist or using a hospital service, you will likely need to be seen in our office **before** we can issue one. Referrals must be initiated by a primary care provider. We cannot issue a referral once services have been rendered. It is your responsibility to know your insurance company requirements.

________ initials **MISSED APPOINTMENTS/ CANCELLING APPOINMENTS**

Missed appointments have a negative impact on the efficiency of our practice, can potentially jeopardize the health of our patients, and disrupt the patient flow and scheduling availability. Healthy Steps Pediatrics requires a **minimum of 24 hours** notice when canceling or rescheduling an appointment. **If you fail to show up for your appointment, you will be charged a $50.00 no show fee.** Insurance does not cover these fees. Cancellations/rescheduling with less than 24 hours notice and missed appointments will be charged.

________ initials **DELINQUENT ACCOUNTS**

A payment can be made with our billing office for past due amounts. Failure to pay or to make payment arrangements of a past due amount may result in a referral to a collection agency. You agree to reimburse us the fees of any collection agency or attorney firm, and all costs and expenses, including reasonable attorneys' fees we incur in such collection efforts. If your account is referred to a collection agency for payment, you will be dismissed from our practice.

I have read and understand the Healthy Steps Pediatrics' Financial Policy and agree to the terms and responsibilities described above. I authorize Healthy Steps Pediatrics, LLC, to release required medical or other information necessary to process my insurance claims. I also authorize payment of medical benefits to Healthy Steps Pediatrics, LLC.

CHILD/CHILDREN'S NAME & D.O.B____

PARENT/LEGAL GUARDIAN SIGNATURE & DATE____

PRINT NAME____

RELATIONSHIP TO CHILD____

3911 Mary Eliza Trace, Suite 500, Marietta, GA 30064 | Phone: 678.384.3480 | Fax: 678.384.3481

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RECEIPT OF NOTICES OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT ACKNOWLEDGMENT FORM

I ___________________________ (parent/legal guardian) acknowledge I have received a copy of the privacy practices and financial policies of *Healthy Steps Pediatrics, LLC*.

I have read and understand the Privacy Practices and Financial Policy of *Healthy Steps Pediatrics, LLC,* and agree to the terms and responsibilities as described in the documents. I authorize *Healthy Steps Pediatrics, LLC,* to release required medical and/or other information necessary to process my insurance claims. I also authorize payment of medical benefits directly to *Healthy Steps Pediatrics, LLC*.

Please print the names of all children, including DOB and age, below:

Name	**Date of Birth**	**Age**

Parent/Legal Guardian Signature: ____

Print Name: ____________________________________ **Date**_________________

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PROXY PERMISSION FORM

Healthy Steps Pediatrics, LLC requires a parent or legal guardian to accompany all patients under the age of 18 for every office visit. All *Healthy Steps Pediatrics* patients who are not accompanied by a parent or guardian must have a completed PROXY PERMISSION FORM prior to their office visit.

List child(ren) DOB and age below:

Name	Date of Birth	Age
______________________	________________	_______
______________________	________________	_______
______________________	________________	_______
______________________	________________	_______
______________________	________________	_______
______________________	________________	_______
______________________	________________	_______

I, ___________________________, (parent/legal guardian) give the following person(s) permission to make medical decisions and to sign any appropriate documents related to my child(ren), in my absence.

Name:____________________ Relationship:________________ Driver's Lic #/State:________________ Phone #: ________________

Name:____________________ Relationship:________________ Driver's Lic #/State:________________ Phone #: ________________

Name:____________________ Relationship:________________ Driver's Lic #/State:________________ Phone #: ________________

I, _______________________________, DO/DO NOT *(circle one)* give my child, ____________________, permission to seek medical treatment by themselves without a parent, caretaker or guardian in accompaniment. I acknowledge that my child is of driving age and has the ability and maturation to understand your medical recommendations.

Signature of Parent/Legal Guardian: ______________________________

Print Name:________________________________

Relation to child/patient: __________________________________

Date: ____________________________________

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NON-COVERED SERVICES

Each insurance company covers different procedures. At Healthy Steps Pediatrics, we utilize patient health questionnaires as screening tools at each of your child's well visits. We have implemented the screens that are specifically recommended by the American Academy of Pediatrics. These tools are critically important to assess your child's overall physical, emotional, nutritional, educational, and developmental progress.

In addition, hearing & vision screening is recommended by the American Academy of Pediatrics during a child's well visit a the ages of 3, 4, 5, 6, 8, 10, 12, and 15 years old. Most insurance companies cover these screenings when they are performed during a well child visit. If either or both hearing & vision screenings are performed outside of the child's well visit at the ages listed above, services may not be covered.

You understand that your insurance company may or may not cover these screening tools.

Patient(s) Name & D.O.B.:____

____

Parent/Guardian Signature:____

Print Name:____

Date:____

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