Privacy Notice and Consent to Treat Acknowledgement and Financial Agreement

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **The Carithers Pediatric Group's Privacy Notice** dated September 3, 2013 ("Notice"). I understand that I am responsible to read this Notice and notify The Carithers Pediatric Group, in writing, of any request for restrictions in the use or disclosure of my child's individually identifiable health information. I understand the notice included electronic access to my child's medical history. The Carithers Pediatric Group has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.carithersgroup.com. The Carithers Pediatric Group will provide me with a copy of its most recent Notice upon my request.

Patient name: ______________________________ **Date of Birth:**______________________

Parent, Guardian or Legal Representative Signature:____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at The Carithers Pediatric Group. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services.

The Carithers Pediatric Group may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay The Carithers Pediatric Group in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to The Carithers Pediatric Group**.** Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

The billing department and/or the office manager handle financial matters, not the doctors. Please direct your questions accordingly.

Settlements / financial responsibilities, such as divorce, must be resolved between the parents. We do not get involved with these issues.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is **my responsibility** to provide The Carithers Pediatric Group with a copy of my child's **current insurance** card. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify The Carithers Pediatric Group immediately upon any change in my insurance**.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card, The Carithers Pediatric Group is not obligated to see my child, but if I still wish my child to be seen, he/she can be seen as a "Private Pay" patient. I agree that neither The Carithers Pediatric Group nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non-Covered Service." I understand services sent to an outside lab are billed to my insurance or to me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS

Annual "well-visit" exams are preventive visits and are not paid for by all insurance carriers. I understand I am responsible for payment, if the exam or portion of the visit is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns, or bill for a separate service.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all immunizations, anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my child's diagnosis and/or treatment.

ADDITIONAL INFORMATION

The Carithers Pediatric Group accepts payments in: Cash, Check, Debit and Credit Cards.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to The Carithers Pediatric Group.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **The Carithers Pediatric Group**. I hereby authorize **The Carithers Pediatric Group** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name ______________________________ **Patient's Date of Birth:**______________________

Patient's Signature (if over 18)________________________ **Date signed:**______________________________

Parent, Guardian or Legal Representative Signature:____

Employee's signature who reviewed intake of form:____

Revised 02/28/2011