OFFICE POLICIES & CONSENT - David Fredenburg MD PA

This is a pediatric office providing primary care for infants, children, adolescents as well as young adults. Please understand, however, that **we are not nor do we want to be your insurance company**. In return, you may have noticed that your insurance company representatives are not here nor do they provide what we consider medical care.

Your relationship with your insurance company is confidential--we do not have access to many aspects of your policy, including uncovered services or certain other restrictions. Most importantly, we do not create or determine the policies imposed on you for your coverage by your insurer. Therefore, understanding aspects of your coverage is yours and your insurer's responsibility. Please consult your insurer or human resource office about any issues you may have regarding coverage or policy requirements, including whether this office is a current provider for your insurer as well as to make certain this office is listed as the primary care provider (PCP). We will attempt to make your life with your insurer as bearable as possible, but we are also limited by their regulations and oftentimes unpredictable procedures and practices.

APPOINTMENTS

Respecting your time, we attempt to schedule appointments realistically. We also try to confirm appointments as a courtesy to you. The scheduling and keeping of an appointment is, however, your responsibility. In order to provide appropriate scheduling and make appointment times more available we request notification as soon as you know an appointment will not be kept. Please be aware that there is a **$25 fee for missed appointments**, whether "no-shows" or cancellations less than 24 hours prior to the appointment. This fee is the parent's, patient's or guardian's responsibility, it will not be issued to an insurer, and must be paid prior to any further appointments being scheduled, recurring missed appointments may also result in termination of care by this office. To avoid schedule disruption and delays, we are unable to accommodate walk-ins.

RECORD TRANSFER/REVIEW

If you change practices an initial copy of the patient records will be provided to you or the new provider's office at no charge. (Please note that there is a prepaid copying fee of up to $0.50 per page if there is a balance owed to the office at the time of transfer, minimum $15.) For confidentiality reasons, a completed and signed medical release form to transfer the office notes is required (a form is available from the office). The transfer request is required prior to processing the records since you may want to restrict releasing some information in the file. Additional copies of patient records are provided at a prepaid cost of up to $0.50 per page. We will make current patient records available for review in the office to an authorized individual when requested at a mutually appropriate time. Clinically relevant records will be made available to other health providers as an important part of appropriate communication and care, records will be limited to the minimum health information necessary to provide health care.

RETURNED CHECKS FOR INSUFFICIENT FUNDS

A $25 service charge is added to all checks returned from the bank for insufficient funds, in addition to the original check amount.

FEES & AGREEMENT FOR PAYMENT

All fees for medical treatment are the responsibility of the parent, patient or guardian. Payment for services is due at the time the service is provided. To assure we have current insurance information, **a current insurance card must be presented prior to each visit**. **Co-payments are required by your insurance company and are due at the time of service** as well. If accurate, current insurance information is available, we will attempt to bill your insurance company as a courtesy. In the event your insurer fails to reimburse this office within 90 days of billing, the balance remains the responsibility of the parent, patient or guardian. The parent, patient or guardian agrees to directly pay for any service that is denied by your insurer for any reason, including lack of authorization, pre-existing conditions, lack of medical necessity as determined by insurer or insurance ineligibility.

I authorize David Fredenburg MD PA to submit to my insurance company/Medicare/Medicaid for reimbursement of care provided and to release any medical information about the services necessary to process the claim. I authorize payment of medical benefits to David Fredenburg MD PA for any services for which there is assignment. I understand that I am responsible for payment of all office services at the time of the visit. I also understand that if it becomes necessary to have delinquent balances referred to an attorney or collection agency, I agree to pay any and all attorney/agency fees to collect the outstanding bills.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA PROVISION)

I authorize David Fredenburg MD PA to use and disclose personal protected health information for treatment, payment and healthcare operations. This practice's Notice of Privacy Practices has been made available for review prior to signing this consent. The Notice of Privacy Practices may be amended as needed to be in compliance with HIPAA, a revised Notice will be available by contacting Dr. David Fredenburg, this practice's designated HIPAA privacy officer. I also consent to office staff contacting me at home or other requested location to discuss or leave messages regarding treatment, payment or healthcare issues, such as appointment reminders, insurance coverage/billing information, or clinical follow-up, including laboratory or x-ray results. The contact may be by telephone, mail, email, or other mutually agreed upon manner. I may revoke this consent in writing at any time for future release of protected health information. If, however, I do not sign or maintain a current consent, I understand David Fredenburg MD PA will be unable to provide further medical care/treatment for me, or my child, in accordance with HIPAA regulations.

I acknowledge that I have read and understand the above policy and consent information. I also have read and understand the Office Welcome regarding office hours, insurance referral information and after hour call coverage.

Patient Name/DOB: _____ Signature: _____

Patient Name/DOB: _____ Relationship to patient(s): _____

Patient Name/DOB: _____ Date _____