Rise & Shine Pediatrics, PC

PATIENT NAME: _____

DATE: _____

FINANCIAL POLICY

Thank you for choosing Rise & Shine Pediatrics (RSP) as your health care provider. It is the policy of this practice to provide the finest quality of medical care available. In an effort to make our services available to as many patients as possible on an affordable basis, this practice employs firm practice management. This enables us to provide the highest level of care, and at the same time be sensitive to cost containment. In an effort to be fair to all patients, we have adopted the financial policy outlined below. **Please take the time to read this policy in its entirety:**

1. PAYMENT IS DUE AT TIME OF SERVICE
2. MOST MAJOR INSURANCE PLANS ARE ACCEPTED AND FILED AS A COURTESY TO OUR PATIENTS.
3. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER CARDS.

Returned (NSF) checks will be charged back to the patient's account with an additional service fee of $30.00. At the discretion of management, returned checks may be resubmitted to your bank a second time. Returned checks not redeemed within 20 working days of written notice to the maker may be subject to prosecution.

Social Security Numbers: We require the disclosure of the guarantor's social security number if payment for services rendered is not made on the date of service. If the patient is self-pay and does not pay in full by either cash or credit card, then we have extended credit and therefore must have the social security number of the guarantor on file. If we are filing insurance and we cannot verify the patient's eligibility and coverage on the date of service, and the patient does not pay for the visit, then we will require the guarantor's social security number.

REGARDING INSURANCE

Your insurance identification card is required at the time of each service. Insurance verification, if performed, is not a guarantee of coverage or payment. Ultimately, your insurance policy/employee benefits plan is your responsibility, and we encourage patients to be aware of their own plan and its allowable services. Additionally, we encourage patients to follow up with their insurance companies to inquire upon knowledge of any unpaid services. If you are uncertain to what items are covered or what you will be responsible for, please contact your insurance company representative for assistance. This phone number will be on your insurance card.

To help reduce paperwork and relieve patients of financial burdens, we have entered into contractual agreements with most insurance and third parties. Patients covered under these programs will be responsible only for the services covered, deductibles and participations in accordance with their specific contracts.

_____ *Initials* If your insurance company/employee benefits plan has not paid for a service within 45 days of being filed, the balance will become your responsibility. At that time, you will be billed for any unpaid services and payment from you is due in full. If your insurance pays after you have paid, you will be reimbursed within 30 days.

_____ *Initials* Co-payments, co-insurance and deductibles are due on the day services are rendered.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein.

_____	_____	_____
Patient or Legal Guardian Signature	**Relationship to Patient**	**Date**

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read the foregoing and understand it.

Parent/Legal Guardian Signature: _____ Date:_____

Rise & Shine Pediatrics, PC

PATIENT NAME: _____

DATE: _____

ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Rise & Shine Pediatrics, PC, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Rise & Shine Pediatrics, PC, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby Rise & Shine Pediatrics, PC, to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Rise & Shine Pediatrics, PC, any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Rise & Shine Pediatrics, PC, or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Rise & Shine Pediatrics, PC, any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Rise & Shine Pediatrics, PC, (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Rise & Shine Pediatrics, PC, all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided Rise & Shine Pediatrics, PC, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Rise & Shine Pediatrics, PC) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Rise & Shine Pediatrics, PC, as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Parent/Legal Guardian Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian (please print): _____

HIPAA PRIVACY NOTICE

I acknowledge that I have been provided a copy of the Notice of Privacy Practices of Rise & Shine Pediatrics, PC. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my information.

_____	_____	_____
Patient or Legal Guardian Signature	**Relationship to Patient**	**Date**