Siena Pediatrics

Patient's Name:_____ Date of birth:_____

Male/Female Race:_____ Ethnicity:_____

Address:_____ Apt No:_____

City:_____ State:_____ Zip:_____

Phone No:_____ Cell:_____ Preferred Language:_____

Father/Guardian's Name:_____

Date of birth:_____ Social Security No:_____

Address:_____ Apt No:_____

City:_____ State:_____ Zip:_____

Home No:_____ Cell phone No:_____

Employer:_____ Occupation:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone No:_____

Mother/Guardian's Name:_____

Date of birth:_____ Social Security No:_____

Address:_____ Apt No:_____

City:_____ State:_____ Zip:_____

Home No:_____ Cell phone No:_____

Employer:_____ Occupation:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone No:_____

*Email:_____ *Pharmacy:_____

Emergency Contact:_____ Phone No:_____

Relation to Patient:_____

Siena Pediatrics is in complies with American Academy of Pediatrics (AAP) on nondiscrimination in pediatric health care and does not discriminate on the basis of race, color, national origin, age, disability or sex.

It is very important that you fill out the insurance portion in its entirety. If it is incomplete, you may be liable for services rendered that return unpaid due to insufficient information.

Primary Insurance

Primary Insurance:_____ Phone No:_____

Address/P.O. Box:_____

City:_____ State:_____ Zip:_____

Policy Holder's Name:_____ Relation to Patient:_____

Date of birth:_____ S.S.#/I. D #:_____

Group No:_____ Policy #:_____

POLICY HOLDER INFORMATION ONLY IF DIFFERENT FROM GUARDIAN:

Policy Holder's Name:_____ Relation to Patient:_____

Date of birth:_____ Social Security No:_____

Address:_____ Apt No:_____

City:_____ State:_____ Zip:_____

Home No:_____ Cell phone No:_____

Employer:_____ Occupation:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone No:_____

SIGNATURE:_____ DATE:_____

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my child's health care, **Wijesinghe Pediatrics PC DBA** originates and maintains paper and/or electronic records describing my child's health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that **Wijesinghe Pediatrics PC DBA** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to **Wijesinghe Pediatrics PC DBA** to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

X_____ _____
Parent signature Date

FINANCIAL AND COLLECTION POLICY

PLEASE READ THE FOLLOWING CAREFULLY:

1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.

2. We bill your insurance as a courtesy, not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.

3. If you have Managed Care insurance, please make sure you have contacted them and named us as your primary care physicians or you will be responsible for payment of services.

4. Photo ID and Insurance card must be provided for each date of service.

5. Basic paperwork requested will take at least 24 hours, FMLA will take a week, and photo ID must be provided during pick up.

6. All outstanding balance must be paid prior to check-in, unless other arrangement have been made.

7. Our office bills are for doctor services only. Fees for lab work or cultures are billed separately by the appropriate lab.

8. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 60 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collections and court costs.

9. Returned checks will be subject to a $35 fee.

10. There will be a $25.00 No Show fee for any appointment that is not cancelled or rescheduled within 24 hours of scheduled visit.

11. If there are 3 No shows on account, you will be discharged from practice, however there will be a 30 days' grace period for sick visits only.

12. If there is any change of insurance, it is the parent's responsibility to notify Siena Pediatrics of the changes.

13. Patient's refund will be release once insurance claim has been paid by your insurance carrier. We want to make sure we deduct any copays, coinsurance, deductibles, or any other charges your insurance carrier may apply towards your responsibility. Time frame is usually 6 to 8 weeks. We do understand that temporary hardships may affect timely payment of your balance.

We encourage you to communicate any problems so that we can assist you in the management of your account. We also offer payment arrangements. You may speak with our billing department for further assistance.

_____ _____

Parent/Guardian Signature Date

NON-CONTRACTED INSURANCES

Listed below are the insurances that our practice is not contracted with. By signing this form, you are acknowledging this list and are aware that if you have any one of these insurances and still continue to proceed with care from our facility, you will be responsible for all charges for that date of service.

Thank you

***Health plan of Nevada HMO**

***Coventry Healthcare Partners HMO**

***Amerigroup Medicaid**

***PacifiCare HMO**

***All exchange plans except HPN Nevada Exchange**

***Blue Cross Pathway except for Tier 2 network**

***Prominence Health plan/ Health Care Partners HMO**

***Cigna Local Plus plans**

***Liberty Health share**

***Standard Life**

***United Healthcare Compass Balanced Plan**

***Aetna Value Network**

_____ _____

Parent/Guardian Signature Date