KidzCare PEDIATRICS

Accessible, Affordable, Quality Care
@ Patient Centered Medical Home

INSURANCE POLICY

1.All insurance recipients must present their current insurance card at the time of service. If you do not have your insurance card you will be considered a self-pay patient.
2. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.
3. Patient/Guarantor will be responsible for all charges incurred if no insurance card is presented or if any amount not paid or covered by their insurance. Services not covered by your insurance company will be due at the time of service. It is your responsibility to know what is covered and what is not.
4. Please notify our office if there are any changes in your insurance coverage or change of insurance of carriers.

This is to certify that I (we) the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and medical treatment by providers, authorized agents and employees of the practice as may, in their professional judgment be deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment.
I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to **KIDZCARE PEDIATRICS, PC** and their associates. If for any reason I fail to meet my financial obligations to **KIDZCARE PEDIATRICS, PC** and their associates, to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by **KIDZCARE PEDIATRICS, PC** in order to carry out treatment, payment, or health care operations. I understand that I should review **KIDZCARE PEDIATRICS, PC** Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form.
KIDZCARE PEDIATRICS, PC reserves for itself the right to change the term of its Notice of Privacy Practices for Protected Health information at any time. If **KIDZCARE PEDIATRICS, PC** does change the terms of Notice of Practices for Protected Health Information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.
I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. **KIDZCARE PEDIATRICS, PC** is not required to agree to such requested restriction(s); however, if **KIDZCARE PEDIATRICS, PC** does agree to my requested restriction(s), such restriction(s) are then binding on **KIDZCARE PEDIATRICS, PC.**
At all time, I retain the right to revoke this consent in writing, to **KIDZCARE PEDIATRICS, PC** except to the extent that action has already been taken.
KIDZCARE PEDIATRICS, PC may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent **KIDZCARE PEDIATRICS, PC** is required by law to treat individuals). If Patient

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(or authorized representative) signs this Consent Form and then revokes Consent, **KIDZCARE PEDIATRICS, PC** has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that **KIDZCARE PEDIATRICS, PC** is required by law to treat individuals).

I fully understand and have read the ***INSURANCE POLICY*** and the ***CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS*** and agree to abide by these policies.

_____ _____

Signature of parent/legal representative **Date:**

_____ _____

State relationship if other than parent **Signature of Witness**

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