

PLEASE COMPLETE INSURANCE INFORMATION

Primary Insurance Company _____

Complete Address _____

Phone Number _____

Subscriber Name _____ **Date of Birth** _____

SSN _____ **Address** _____

Subscriber ID # _____ **Group #** _____

Secondary Insurance Company _____

Complete Address _____

Phone Number _____

Subscriber Name _____ **Date of Birth** _____

SSN _____ **Address** _____

Subscriber ID # _____ **Group #** _____

Third Insurance Company

Complete Address _____

Phone Number _____

Subscriber Name _____

Subscriber ID # _____ **Group #** _____

PAYMENT IS DUE at the time of service. All Co-payments will be collected prior to visit. If for some reason a co pay is not left and a bill needs to be sent for the co pay, a \$5.00 charge will be added to the bill. All extended credit must be approved through the office manger. Any balance over 60 days may receive a finance charge of 12% annum. I authorize assignment of benefits to Idaho Falls Pediatrics and authorize above named clinic to release any information requested to receive payment. If collection becomes necessary, the undersigned shall pay any expense incurred for collection procedures including court and attorney fees.

SIGNATURE (Parent or Legal Guardian) _____

DATE _____



Idaho Falls Pediatrics

2375 Coronado, Idaho Falls, ID 83404
Ron Porter M.D. • Scott Smith D.O. • Joseph Moore M.D.
Stephanie Newberry PAC • Darin Leslie PAC
(208)522-4600 • Fax (208) 552-7521

In consideration of professional services rendered, I agree to pay your customary charges for these services to Dr. Ron Porter, MD or Dr. Scott Smith, DO or Dr. Joseph Moore, MD, Stephanie Morgan, PA-C, or Darin Leslie, PA-C. As a benefit to our patients this office submits insurance claims directly to your insurance company. It is however, **ultimately your responsibility** to be sure that the claim is paid by the insurance company. I hereby authorize Dr. Ron Porter, Dr. Scott Smith, Dr. Joseph Moore, or Stephanie Morgan to receive assignment of insurance payments. If the customary charges are more than the benefits allow under the responsible party's insurance plan, and we are not participating providers with said plan, I agree to pay the difference. I understand that if it becomes necessary to turn this account to collections, collection fees and interest will be charged and I will be responsible for them.

NAME OF PARENT OR GUARDIAN

PRINT _____

SIGNATURE _____

DATE _____

I authorize Dr. Ron Porter, Dr. Scott Smith, Dr. Joseph Moore, MD, Stephanie Morgan, PA-C, or Darin Leslie, PA-C to release any medical or incidental information that may be necessary for either medical care or in processing applications for medical or financial benefit.

SIGNATURE OF PARENT OR GUARDIAN

PRINT _____

SIGNATURE _____

DATE _____

OUR FINANCIAL POLICY

Thank you for choosing Idaho Falls Pediatrics as your healthcare provider. We are committed to your children's treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

All Patients must complete our information and Insurance form before seeing the doctor. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE. PATIENTS WITH NO INSURANCE WILL BE OFFERED 15% OFF OF BILL IF IT IS PAID IN FULL AT THE TIME OF SERVICE.

WE ACCEPT CASH, VISA AND MASTERCARD AND DISCOVER. WE NO LONGER ACCEPT CHECKS

Regarding Insurance

We will file your insurance as a courtesy to you and will do our very best to maximize your benefits. It is your responsibility to understand your insurance benefits (what they will or WILL NOT pay for.) Some insurance companies WILL CHARGE A DIFFERENT COPAY OR CO INSURANCE AMOUNT WHEN SEEING A PA INSTEAD OF A DOCTOR. It is your responsibility to pay it and check with the insurance company. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All co-pays and deductibles are to be paid at the time of service. If co-pay is not left, we reserve the right to assess a \$5.00 charge in addition to the charges for that day. If there is a problem with a claim, you will need to contact your insurance company. PLEASE DO NOT CONTACT OUR BILLING OFFICE UNTIL YOU HAVE SPOKEN WITH YOUR INSURANCE COMPANY. After you contact the insurance company, if there is anything we need to do to assist you, please call and let us know. You are responsible for the amount your insurance company does not pay. We do contract with most insurance companies and will take their usual and customary allowances. If, however, you happen to have an insurance that we are not contracting with, you are responsible for the full remainder of the bill after insurance pays.

IT IS YOUR RESPONSIBILITY TO UPDATE ANY INSURANCE CHANGES. WE WILL NEED TO KNOW THE NAME OF THE INSURANCE COMPANY, ADDRESS, PHONE, ID NUMBER, GROUP NUMBER, POLICY HOLDER NAME, DATE OF BIRTH AND SSN OF THE POLICY HOLDER, AND THE DATE THE NEW INSURANCE BECAME EFFECTIVE.

MEDICAID: If you have Medicaid and your Medicaid is ineligible the day of your visit, you will be required to pay in full at the time of service or reschedule until you can get your Medicaid fixed.

Minor Patients

An adult must accompany any child under 18 years of age. The adult or guardian accompanying the minor is responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied.

Missed Appointments

Appointments must be canceled at least 24 hours in advance. Our policy is to charge for missed appointments at a rate of \$30.00. Please help us serve you better by keeping scheduled appointments.

Updated Information

Please make sure all Addresses and phone numbers are kept current.

DELINQUENT ACCOUNTS

If at any time your account is delinquent and we are unable to contact you, we may send your account to CBS Collection Agency.

DIVORCE

In case of a divorce, neither Idaho Falls Pediatrics, nor its providers, is party to the divorce settlement. If your ex-spouse is obligated to pay, that is up to YOU to enforce, not the doctors.

OVERPAYMENTS

Overpayments will be returned to the parent or guardian after all the insurance has come through.

These financial options will meet the needs of most families in our practice. We want to be flexible in these changing times. We will do our very best to work out a financial solution to your particular situation. We are here to help you.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL STATEMENT.

Signature: _____

DATE _____

Child's Name _____

Date of Birth _____



Idaho Falls Pediatrics

2375 Coronado, Idaho Falls, ID 83404
Ron Porter M.D. • Scott Smith D.O. • Joseph Moore M.D.
Stephanie Newberry PAC • Darin Leslie PAC
(208)522-4600 • Fax (208) 552-7521

On occasion, you may wish to have your child/children brought to the Clinic by someone other than a parent. Please the list of those individuals (A grandparent or a daycare provider, for example) who have your permission to bring your child in for assessment and treatment.

My child _____, may be brought in for assessment and treatment by the following individuals:

NAME

RELATIONSHIP TO CHILD

Custodial Parent or Legal Guardian

Witness

Date

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that notice for further information.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To Family members or close friends who are involved in your health care
- For purposes of public health and safety
- To Government agencies for purposes of their audits, investigations and other oversight activities
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by law

Patient Rights

As our patient, you have the following rights

- To have access to and and or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

I authorize the release of information to the following person (s): _____

I acknowledge that I have read or had the opportunity to read if I so chose and understand the Notice.

Childs Name _____ Date of Birth _____

Parent or Guardian Printed Name

Date

Signature of Parent or Guardian:
