ABC Pediatric Clinic Office Policy

Acknowledgement of Review of Notice of Privacy Practices

- I have reviewed this office's Notice of Privacy Practices, which explains how my child(ren)'s medical information will be used and disclosed.
- I understand that I am entitled to receive a copy of this document.

Office Policy

- **Late Policy**- if you arrive 15 minutes past your appointment time, your appointment will be rescheduled.
- **No Show Policy**- appointments must be cancelled 1 hour prior to appointment time. if you have three no shows you will be required to sign a no show. On your fourth no- show, you will be dismissed from the clinic.
- **Vaccine Policy**- vaccine records are required for all new patients. ABC Pediatric Clinic requires all of its patients to be vaccinated on schedule per CDC guidelines.
- **Transfer Policy**- once you change PCP or transferred records to another PCP, you will be inactivated in our system and will not be allowed to return.
- **I have read and understand this office's policies which explain the term and conditions of this office in regards to appointments, no shows, vaccination records, vaccination requirements and transfer to another facility.**

Financial Policy

- I understand that the accompanying parent or adult is responsible for full payment at the time of service.
- I hereby authorize direct payment of medical benefits to ABC Pediatric Clinic for services rendered in person or under supervision.
- I understand that I am financially responsible for any balance not covered by my insurance.
- I authorize ABC Pediatric Clinic to release information as required to my insurance company or third-party payer for the purpose of determining benefits.
- I understand that such records may include HIV/AIDS testing, substance and or mental-health issues.
- I authorize ABC Pediatric Clinic to bill my insurance or third-party payer and receive payment directly from billing at the time of service unless other arrangements are made with the financial department.
- I understand that I remain financially responsible for all charges not covered by the insurance company.
- I authorize the use of this signature on all insurance claims.
- I understand that Patient(s) who are not eligible for Texas Medicaid or CHIP on the date of service will not be reimbursed for any out of pocket expenses. This includes retroactive Medicaid or CHIP plans. By signing this policy, I am consenting that ABC Pediatric Clinic is not responsible for submitting retroactive patient claims to Medicaid or CHIP plans.
- I understand that if the discussion goes beyond the scope of the routine exam during the child's well visit, my insurance company requires the payment of a co-pay, deductible or co-insurance (patient responsibility). Payment will be expected at the time of the visit.
- I understand that before making an annual physical (well child) appointment I will check with the current insurance carrier regarding covered and non-covered charges. Not all plans cover annual hearing, vision and other screenings. If it is not covered, it is understood, that I will be responsible for payment on the allowable amount at the time of visit.
- **Authorization for Credit Card on File Program:** I authorize ABC Pediatric Clinic to charge my credit card on file for all balances which my health insurance plan deems as "patient responsibility" i.e. co-pay's, deductibles, non-covered service, etc.
- I understand that once my health insurance has processed my child's claims, I will receive an Explanation of Benefits (EOB). The EOB will show any balances due that is the responsibility of the patient.
- I agree that if payment is not made by the date indicated on the statement mailed to me then ABC PEDIATRIC Clinic may charge my credit card on file for the balance due. I will receive a courtesy reminder prior to my card being charged.
- I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further routine well appointments until the balance has been paid in full.

Insurance Plans

- I understand that it is my responsibility to keep ABC Pediatric Clinic updated with the correct insurance information.
- It is my responsibility to understand the patient's benefit plan.
- Upon arrival, I will come prepared to present the proper insurance card at every visit to verify that ABC Pediatric Clinic has the most updated card on file.
- If the insurance card/plan presented is incorrect or invalid, I will be responsible for payment of the visit and I must submit the charges to the correct plan for reimbursement.
- If the proper insurance carrier has not been informed that ABC Pediatric Clinic or one of its providers is the primary care provider, then the visit must be paid in full or the visit must be rescheduled.
- I am authorizing ABC Pediatric Clinic to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers or my health insurance. I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to ABC Pediatric Clinic.

ABC Pediatric Clinic Office Policy

Consent for registration of Child & Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- A public health district or local health department, for public health purposes within their areas of jurisdiction;
- A physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- A state agency having legal custody of the child
- A Texas school or child-care facility in which the child is enrolled
- A payer currently authorized by the Texas Department of Insurance to operate in Texas regarding coverage for the child.
- I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group-MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.
- By my signature, I grant consent for registration. I wish to include my child's information in the Texas immunization registry.

Telemedicine Consent

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.
- I understand the telemedicine process including the video conferencing technology, and that I may ask the provider any question regarding the telemedicine consultation, including the risks, benefits and alternatives
- I understand that a limited physical examination will occur during the telemedicine consultation and I may elect to discontinue the consultation at any time without affecting my right to a future telemedicine consultation
- I understand that there are alternatives to a telemedicine consultation, and I may elect, at any time, for a direct consultation by any healthcare provider at any medical office or emergency facility
- I understand that the transmission of medical information could be interrupted or distorted during the consultation due to technical difficulties.
- I understand that the video picture or any information may not be transmitted clearly to render an accurate determination; and the provider may recommend a follow-up visit at the medical office, or an urgent care center or emergency facility
- I understand that Not every medical condition should be evaluated using telemedicine; escalating medical conditions should be evaluated by direct contact with a provider
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing by contacting ABC Pediatric Clinic's Privacy Officer at 713-455-7777. As long as this consent is in force (has not been revoked) ABC Pediatric Clinic and its providers may provide health care services to me via telemedicine without the need for me to sign another consent form.
- I understand that I will be responsible for any copayments, coinsurances, or deductible that applies to my telemedicine visit. If my insurance does not cover telemedicine, I understand I will be responsible for the balance.

General Photography Release

I hereby authorize ABC Pediatric Clinic, to publish photographs taken of me on Clinic events, for use in the ABC Pediatric Clinic's website, Facebook, prints, online and video-based marketing materials, as well as other Company publications. I hereby release and hold harmless ABC Pediatric Clinic from any reasonable expectation of privacy of confidentiality associated with the images specified above.
I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.
I hereby release ABC Pediatric Clinic, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

☐ (Check this box if you consent to the General Photography Release above)

I have read and fully understand this office policy in its entirety.
He leído y comprendo completamente esta política de la oficina en su totalidad en Español

Child Name: **Date of Birth**

Parent/Legal Guardian Name:

Parent/Legal Guardian Signature: **Date**