Southeast Denver Pediatrics, P.C.

2121 S. Oneida, Ste. 200 • Denver, Colorado 80224-2551 303 • 757-6418 • FAX 303 • 757-2209
11960 Lioness Way, Suite 200 • Parker, Colorado 80134 303 • 471-5060 • FAX 303 • 471-5062

PLEASE INCLUDE ALL INFORMATION

Children:	Last Name	First Name	MI	Birthdate	Sex

Primary Care Physician: ☐ Hand ☐ Sagel ☐ Tucker ☐ Schwartz ☐ Miga ☐ Carlson ☐ Erdley

Name of Friend/Relative/Emergency Contact: _____

Phone: _____ Address: _____

☐ Father ☐ Mother ☐ Other/Relationship _____

Insurance Subscriber ☐ Person Responsible for Bill ☐

Name: _____

Address: _____

City, State, Zip: _____

Home Phone : _____ Birthdate: _____

Driver's License #: _____State: _____

Social Security #: _____

DAYTIME/CELL PHONE: _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone #: _____ Ext.: _____

☐ Father ☐ Mother ☐ Other/Relationship _____

Insurance Subscriber ☐ Person Responsible for Bill ☐

Name: _____

Address: _____

City, State, Zip: _____

Home Phone : _____ Birthdate: _____

Driver's License #: _____State: _____

Social Security #: _____

DAYTIME/CELL PHONE: _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone #: _____ Ext.: _____

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Copay: _____
Subscriber Name: _____ ID/SSN#:_____
Group (GRP): _____
Insurance Company Address: _____

Secondary Insurance Co. Name: _____ Copay: _____
Subscriber Name: _____ S.S./Subscriber #:_____
Group #:_____
Insurance Company Address: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to Southeast Denver Pediatrics for services rendered. I understand that I am financially responsible for any balance not covered by insurance.

Date: _____ Signature: _____

Relationship to Patient: _____

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Non-coverage Disclaimer

Dear Patient:

Your insurance policy may determine that a particular service is not a covered benefit. Nevertheless, you and your physician may still believe that the service is important for your child's care and development.

Possible reasons for non-coverage by your policy are:

- A service is excluded from your individual policy.
- Your insurance company considers a particular service as "unnecessary".
- You do not have "routine benefits".
    - It is the patient's responsibility to make sure they have appropriate coverage for services provided.
    - Routine physicals are billed as such including all screenings and procedures that are recommended by the American Academy of Pediatrics, and may also include charges for services provided addressing any health problems or concerns that are presented at the time of/or in addition to the regularly scheduled exam.
    - If you do not have "routine benefits", you will be responsible for paying the balance for services rendered.

We are unable to appeal claims that have been denied as "non-covered" by your plan. If you have questions regarding billing, please contact our billing department or the Practice Manager. If you have questions regarding your coverage or the processing of a claim, please contact your insurance company.

Beneficiary Agreement:

I have been notified by my physician that my insurance company or plan may deny payment for services provided per the terms of my insurance policy. If my insurance company denies payment, and assigns the remaining balance as "patient due", I agree to be personally and fully responsible for payment. I understand that my physician's office is unable to appeal or re-bill any services that are denied due to non-coverage.

_____ _____

Signature Date

_____

Printed Name

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Office Policies

In order to continue providing high quality medical care to your children, it has become necessary that we, the doctors at Southeast Denver Pediatrics, formalize our practice policies. Please review and sign this form prior to leaving the office today so that it may be included in your family's medical chart. We are happy to provide an additional copy for your records.

Well Child Exams:

Regularly scheduled "check ups" are important in the medical care of your children. In addition to monitoring growth and development and providing vaccination, these visits are intended to address your concerns. They are typically scheduled for 30 minutes and scheduled 6 to 8 weeks in advance.

1) Rescheduling and Missed Appointments: If it is necessary to cancel or reschedule an appointment, please do so as soon as possible. **A $50.00 Fee will be charged to those who do not provide 24 hours notice for the cancellation of a Well Child Exam (this includes Med Checks, ADHD Evaluations, and other regularly scheduled 30 minute appointments). A $25.00 fee will be charged to those who do not provide 24 hours notice for the cancellation of any other regularly scheduled appointments (this does not include same-day or next-day appointments).** Also, because "No Show" appointments make it difficult for others to schedule Well Child Exams, three "No Shows" per family may result in dismissal from our practice.

2) Late Arrivals: Families and patients arriving more than 10 minutes late for their scheduled Well Child Exam may be asked to reschedule for a future date. Late arrivals for check ups decrease the amount of time that we can spend addressing your concerns and create unplanned delays for patients scheduled later in the day.

Acute/Urgent Visits:

We try to provide accessible and timely medical care for patients who are ill. Visits are usually scheduled for 10 to 20 minutes depending on the anticipated complexity of the illness. Generally, these appointments can be made on a "same-day" or "next-day" basis.

1) Emergency/Urgent Visits: If your child is ill or injured, please call before coming in to the office. Patients who arrive without a scheduled appointment may be asked to wait or return for the next available appointment at the discretion of our medical staff. We do not set aside time for "walk-in" visits. Therefore, in order to ensure adequate time and attention for your child, it is best to have a scheduled appointment.

2) Saturday Visits: Saturday appointments are *not* regularly scheduled office hours. We reserve Saturday visits for emergent patients only. There will be an additional charge if your child is seen in our clinic on a Saturday.

All Office Visits:

1) Multiple Children and Siblings: If you will have more than one child who needs medical attention at a visit, please tell the person scheduling your appointment. Even seemingly minor problems deserve the full attention of a scheduled appointment. "Add on" visits may be asked to wait or return for the next available appointment.

2) Co Pays and Payments: As a condition of many insurance plans, **Co Pays for each child must be paid for each office visit at the time of service**. It is your responsibility to know whether or not you owe a Co Pay. If it is not paid at the time of service, **a $25.00 fee will be billed to you in addition to your Co Pay to cover the cost of additional processing**. If you have questions regarding a bill, or feel that you may need special payment arrangements, please contact our office manager as soon as possible.

3) Delinquent Accounts: Failure to provide prompt response to a past due account may result in that account being turned over to a collection agency. Any family referred to a collection agency will be dismissed from our practice. Following notification of dismissal from the practice, we will be available to provide emergency care for 15 days while a new primary care relationship is established.

4) Children under the age of 18 must be accompanied by a parent or legal guardian at EVERY VISIT.

If you have any questions or comments regarding these policies, please feel free to address them with our Practice Manager or Doctors.

Thank You!

I have read and understand the above:

_____ _____

Parent/Guardian Signature Date

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Provider Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We use health information about your child for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Charts and information are shared between providers working at Southeast Denver Pediatrics. Duplicate or unnecessary materials generated containing individually identifiable health information are disposed of in a manner that protects patient privacy. Continuity of care is part of treatment and your child's records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods.

We may use or disclose identifiable health information about your child without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post a new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

In most cases, you have the right to look at or get a copy of health information about your child with a written request. **If you request copies, we will charge you only normal photo copy fees. Our charge is not to exceed $14.00 for the first ten or fewer pages, $0.50 per page for pages 11-40, and $0.33 for every additional page thereafter.** Actual postage or shipping costs are additional. You also have the right to receive a list of instances where we have disclosed health information about your child for reasons other than treatment, payment, or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your child's record is incorrect or is missing, you have the right to request that we correct or add the missing information or you may submit an amendment to your medical records.

If you are concerned that we have violated your child's privacy rights, or you disagree with a decision we made about access to your child's records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon written request.

We are required by law to protect the privacy of your child's information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

If you have any questions, please contact:
Lisa Maxwell, Practice Manager
2121 S Oneida St, Ste 200
Denver, CO 80224
Ph: 303-757-6418

Please sign below and return.
Acknowledgement of receipt of Notice of Privacy Practices:

Signature: _____

Printed Name: _____

Child's Name(please note all children if there are siblings): _____

Date: _____

Second Layer: For further details about your child's rights and the Federal Privacy Rule, please read the second layer attachment.

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Modern Payment Agreement

In an effort to "Go Green", Southeast Denver Pediatrics has implemented an automatic bill pay system. We ask for your cooperation and support.

You will be asked for either a) a credit card number, or b) your bank routing number and checking account number. (You may also use your HSA/FSA account information.) This information is securely held by Modern Payments, Inc. and will only be used to pay any outstanding balances after we have received the explanation of benefits (EOB) from your insurance provider. You will be notified by Email three business days prior to any funds being withdrawn from the account provided. **You must still pay your co-pay at the time of service.**

The implementation of this system will not compromise your ability to dispute a charge or question your insurance company's determination of payment. You may dispute a charge at any time with your bank, credit card company, or with Modern Payments, Inc.; however, the amount of a charge may only be disputed and resolved with your insurance provider.

In order for this system to work, a few things are imperative:

1) You must provide **legible, accurate account and contact information.**
2) You must **review your EOB** as soon as you receive it from your insurance provider.
   Your EOB explains the charges you are responsible for.
3) You must check your Email following visits to SEDP in order to receive notification of charges to your account.

If you have any questions about the automatic bill pay system, please feel free to contact us. Thank you for your cooperation and support.

I have read and understand the above:

_____ _____

Parent/Guardian Signature Date

_____

Name (Please Print)

_____

Email Address (Please Print)

To be applied to the following patients:

Name: Date of Birth:

_____ _____

_____ _____

_____ _____

_____ _____

NetDeposit®

Electronic Payment Authorization Form

COMPANY INFORMATION			
Company Name Southeast Denver Pediatrics	Merchant ID		
Street Address 2121 S Oneida St, Suite 200	City Denver	State CO	ZIP Code 80224

PAYOR INFORMATION			
Name and Title	Phone	Fax	Email
Address	City	State	ZIP Code

PAYMENT PLAN	
Total Payment Amount	Start Date
Number of Payments	Frequency of Payments ☐ One-Time ☐ Weekly ☐ Monthly ☐ Other
Fee per Payment	Total Amount per Payment

PAYMENT INFORMATION	
☐ Charge my Bank Account	☐ Charge my Credit Card
Bank Name:	Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Name on Account:	Card Number:
RT Number:	Expiration Date:
Account Number:	

SIGNATURE AND AUTHORIZATION

I authorize NetDeposit, LLC, on behalf of the Company to debit my account as identified above according to the terms stated here. This authorization shall remain in effect until the balance is paid in full or Company receives written notification from me of any intent to terminate this payment plan and at such time and in such manner as to afford Company reasonable opportunity to act (minimum of 30 days).

I understand that if the total amount owed to Company is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed to Company is paid off, or unless the plan is terminated earlier by me above. I understand any added amounts can be applied for with a new authorization form.

All other changes such as payment amount, frequency, and bank account or credit card numbers, will require a new Electronic Payment Authorization Form to be filled out and submitted to NetDeposit, LLC 15 days prior to any change being implemented. I understand that this payment plan may be cancelled by Company or NetDeposit, LLC, due to Non Sufficient Funds (NSF). I understand that I will be liable to pay the NSF fees that will be charged by my bank.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this electronic payment plan. I indemnify and hold Company, the bank, NetDeposit, LLC, harmless from damage, loss, or claim resulting from all authorized actions hereunder.

Signature	Date
Print Name	Title