PRIME PEDIATRICS & ADOLESCENT

Patient Name: _____ Date of Birth: _____

Financial Responsibility

I understand that it is my responsibility to check that my child is covered by my insurance. It is also my responsibility to pay ALL DEDUCTIABLES as shown in the insurance records. I also understand that I shall be billed for any amount not paid by insurance. If I fail to pay this bill in a reasonable time, it will be sent for collection.

I understand that every time I see the Doctor I shall pay the required Co-pay, even if it is for a follow-up visits.

Office Policy

- Waiting Time: Every effort is made to see you at the appointed time. In case of delay please do not become hostile to the staff or Doctor. Such patients will be discharges from our practice.
- Referrals: If a referral is needed you will need to be seen by Dr. Ali and if Dr. Ali decides a referral is necessary, she will do so. No referrals are made over the phone.
- Medications: If a medication is needed, the patient must be assessed by Dr. Ali first. Once the medication is prescribed and the patient needs a refill please call the office and allow 24 hours for the refill to be ready for pick-up.
- No Show/Cancellation of Appointments: If you are unable to keep an appointment, we recommend you cancel the appointment well in time. **If you have 3 no show appointments, you will be discharged from our office due to noncompliance with scheduled appointments.**.
- I understand that Dr. Ali has the right to discontinue my care at any time without a 30 day advance termination notice if I do not do the following: a) keep scheduled appointments, b) follow instructions concerning my care, c) keep my account paid to date, d) update this office immediately of any insurance changes. **I release her/her corporation from any liability at any time for this terminations**
- There is to be no video recording or face timing during office visit, Also, please end your phone conversations before stepping back into exam area.

Date: _____

Initial: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Prime Pediatrics & Adolescent to disclose all or any part of the patient's medical record and/or clinic charges (including information regarding alcohol or drug abuse, psychiatric illness or communicable disease related information including HIV) to any person or corporation (i) which is or may be liable or under contract to Prime Pediatrics for reimbursement, subrogation and/or direct recovery and coordination of benefits for this and all future claims including but not limited to hospital/medical service companies, workers' compensation carriers, welfare funds, governmental agencies and (ii) any health care provider for continued patient care. Except, as above, Prime Pediatrics will require the patient's, or in the case of a minor child, a natural parent or legal guardian's, written consent to release information about the patient. I also agree that in all instances, the original medical records (including x-rays and laboratory specimens) remain the property Prime Pediatrics & Adolescent, Flint MI.

ASSIGNMENT OF BENEFITS

In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of policy of insurance insuring the patient or any other party liable to the patient, those benefits are hereby assigned to Prime Pediatrics & Adolescent for application against the patient's bill. Such payment shall discharge that insurance company of any obligation under the policy to the extent that payment has been made correctly according to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or not covered by this assignment.

I assign the benefits payable for services to Prime Pediatrics and Adolescent furnishing the services or authorize such organization to submit a claim for payment. Any benefits of any type under any policy if insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Prime Pediatrics & Adolescent.

CONSENT TO TREAT A MINOR

By signing below, I state that I am the natural parent or legal guardian having legal custody of _____, a minor, and age ____, born on _____. I give permission for Prime Pediatrics & Adolescent to perform or administer examination, anesthetic, medical or surgical diagnosis and/or treatment under the general or special supervision and on the advice of any physician or surgeon licensed in the State of Michigan, when the need for such treatment is clear, and when efforts to contact me are unsuccessful. This authorization shall remain effective until the patient is discharged from this practice.

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about the privacy rights of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulation requires that we give our patients or their authorized representative the opportunity to review our Notice before signing this acknowledgment. A copy of our Privacy Policy is available at the front desk. If you are requiring a detailed copy of the information of Health Insurance Portability and Accountability Act please ask us for the Privacy Policy.

By signing this form I am in agreement to all the above sections and understand and accept my Financial Responsibility.

_____

Signature of Patient or Authorized Representative Date

_____

Print Name of Patient and Print Name of Authorized Representative