Pediatric Associates of Lafayette, LLC

FINANCIAL AND OFFICE POLICY AGREEMENT

We are committed to providing the best possible care to our patients and their families, and feel this goal is best achieved if everyone is aware of our policies.

I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS. THOSE SERVICES THAT ARE DEEMED NON-MEDICALLY NECESSARY OR NON-COVERED WILL BE MY RESPONSIBILITY.

PAYMENT FOR OUR SERVICES IS DUE AT THE TIME OF SERVICE, *REGARDLESS OF WHO BRINGS IN THE CHILD*. This includes copays, coinsurance and deductibles stipulated in your insurance policy for our participating insurance companies. You can pay cash, check, money order, VISA or MasterCard. **Failure to pay in full at time of service can result in additional finance charges applied to the outstanding balance once it is over 30 days old.**

I UNDERSTAND THAT I MUST PROVIDE ALL INSURANCE CARDS AT EACH VISIT. If we are a participating provider with your health plan, we will submit a claim on your behalf to your primary carrier with benefits assigned to P.A.L. Unless you provide us with an up to date insurance card, you will be responsible for paying our charges. WE DO NOT SUBMIT SECONDARY CLAIMS FOR PROCESSING UNLESS WE ARE REQUIRED TO BY OUR CONTRACT WITH THE HEALTH PLAN.

I UNDERSTAND IT IS MY RESPONSIBILITY TO ENROLL MY NEWBORN INFANT WITH MY INSURANCE CARRIER WITHIN 30 DAYS OF THE DATE OF BIRTH. Unless you do this, the child will have no insurance coverage under your policy. In the event that you have not enrolled your newborn within 30 days following birth, you will be billed for the services we have provided. If your insurance carrier requests other insurance information from you, they will not reimburse us until you provide it. If you do not do so within 15 days of their request, you will be billed for the charges for our service.

If you are unable to keep a scheduled appointment, please call NO LATER THAN 24 HOURS IN ADVANCE. Messages can be left on the weekends and after hours for unexpected emergencies, which may require cancellation of an appointment. Missed appointments are bad for all concerned and may prevent some other child from being seen. We reserve the right to charge for missed or late cancelled appointments. We document missed appointments and excessive abuse may result in discharge from the practice. **There is a $75.00 charge for all WELLNESS VISITS AND PRESCHEDULED SICK APPOINTMENTS when a patient fails to show or if the appointment is not cancelled within 24 hours in advance.**

We recognize the importance of everyone's time and it is our goal to have you seen within a timely manner. You may help by arriving promptly for your appointment, having all necessary paperwork (insurance card, copay and required forms). Please contact our office in advance if any special billing arrangements are needed. Late arriving patients may be asked to reschedule or they will be worked in around those patients who arrive on time.

SCHOOL EXCUSES: please ask for one at time of service

IMMUNIZATION RECORDS: there is a $5 charge for each vaccine record that is not requested at the time of the visit. The record must be picked up at the office. A $10 charge will apply should you need the form faxed or mailed. Please note that we will only fax this form to schools are daycares and a prepayment will be required.

FORMS: must be left at our office for at least 48 hours and there is a $10 charge for each form filled out that is not brought in at the time of the visit. This includes school, camp and WIC forms. These forms must be picked up from the office once they have been completed by the physician.

Your billing receipt includes all information necessary for submission to your insurance company. They should also be kept for income tax reasons. Overpayments will be returned within 60 days after all outstanding charges are paid on the account.

I agree that should my claim be denied or remain unpaid for a period exceeding 60 days; I will assume full responsibility for payment. If the account is turned over to an outside collection service, I agree to pay all fees associated with collecting unpaid balances.

Our billing office is open Monday-Friday, 8-5 and can be reached by calling (337) 289-8989. Please call if we can be of further assistance.

Please indicate your agreement with this policy by signing below:

_____ _____

Signature Date

437 Heymann Boulevard • Lafayette, Louisiana 70503 • (337) 289-8989 • FAX (337) 289-8990

Pediatric Associates of Lafayette, LLC
437 Heymann Boulevard
Lafayette, La 70503

I hereby certify that I am the parent, guardian, or otherwise am legally authorized to give consent for treatment of this minor and hereby give such consent for treatment by employees of Pediatric Associates of Lafayette, LLC.

I understand that I am ultimately financially responsible for all charges incurred on behalf of my child, and will also be responsible for any charges incurred with the collection of this account. (ie: collection agency fees, legal fees, etc.) A photocopy of this agreement is to be considered as valid as an original.

_____ _____

Signature Date

Patient Medical History Form

Mother's Name _____ Age _____
Occupation _____
Father's Name _____ Age_____
Occupation _____

Child Care Arrangements _____
Siblings: _____ Age_____
_____ Age_____
_____ Age_____

Current and Past Medical History

Check where the child or members of the child's family (parents, siblings, grandparents, aunts or uncles) have had the following illnesses or problems

Illnesses	Child	Family
Alcohol / Drug Abuse	☐	☐
Allergies	☐	☐
Anemia / Blood Disorders	☐	☐
Asthma / Wheezing	☐	☐
Cancer	☐	☐
Croup	☐	☐
Cystic Fibrosis	☐	☐
Diabetes	☐	☐
Eczema	☐	☐
Eye Problems	☐	☐
Frequent Ear Infections	☐	☐
Hearing Problems	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Lung Disease / Tuberculosis	☐	☐
Mental Health Illness	☐	☐
(anxiety/depression)	☐	☐
Seizures/ Convulsions	☐	☐
Sexually Transmitted Diseases		☐
Sudden Death		
Other Illnesses:		
_____		

DATE: _____ CHART#: _____

RESPONSIBLE PARTY: _____

ADDRESS: _____

_____

PATIENT NAME: _____

SIBLINGS:

PHONE NUMBERS

☐ MOM – NAME: _____

CELL#: ( ) _____ HOME#: ( ) _____

WORK#: ( ) _____

☐ DAD – NAME: _____

CELL#: ( ) _____ HOME#: ( ) _____

WORK#: ( ) _____

EMERGENCY CONTACT

☐ NAME: _____ RELATIONSHIP: _____

CELL#: ( ) _____ HOME#: ( ) _____

WORK#: ( ) _____

Authorization to Leave Messages on Voicemail/Answering Machines

Under state law, our office is not permitted to leave specific medical information on voicemail without your consent. I understand that signing this form allows Pediatric Associates of Lafayette, LLC to leave voicemails on the phone numbers listed above with detailed Information (lab/xray results, referral information, follow-up information, or any other pertinent information not specifically listed)

- I understand this authorization is not mandatory or required
- I understand that if I wish to void this authorization, I must do so in written form addressed to the office manager

_____ Yes, please leave me a message at the numbers listed above (check box)

_____ No, please do not leave me any detailed messages.

Signature of Parent/Legal Guardian _____

DATE: _____ CHART#: _____

RESPONSIBLE PARTY: _____

ADDRESS: _____

_____

PATIENT NAME: _____

SIBLINGS:

PHONE NUMBERS

☐ MOM – NAME: _____

CELL#: ( ) _____ HOME#: ( ) _____

WORK#: ( ) _____

☐ DAD – NAME: _____

CELL#: ( ) _____ HOME#: ( ) _____

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