Patient Name: ______________________________

CONSENT FOR TREATMENT

I grant permission to the attending physician(s) and professional staff or to their designees at Carolina Developmental Pediatrics, PA (CDP) to render medical treatment or diagnostic procedures including psychological/neurodevelopment, physical and educational assessment as deemed necessary during my child's care. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made regarding the result of treatments or examinations.

RELEASE & ASSIGNMENT OF BENEFITS

I authorize CDP attending physician(s) and professional staff, or their designees to release medical information and billing information including, but not limited to information about my child's diagnosis, care and treatment for financial coverage to any third party or its agents requesting medical and other information for the purpose of determining eligibility for insurance or other public benefits, processing insurance claims or assessing quality, cost and appropriateness of medical care.

I hereby assign to CDP any insurance or other third-party benefits available for health care services provided to me. I understand that CDP has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CDP, I agree to forward to CDP all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt

HIPAA COMPLIANCE

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. It is the policy of CDP to keep your information private except as stated above, and within the limits of the law. By signing this document I hereby state that I have had the opportunity to review the HIPAA documents and had any questions answered. I understand that this consent shall remain in force from this time forward and that I may revoke my consent at any time in writing.

COMMUNICATIONS

By my signature below, I give consent for CDP to contact me via phone, text or e-mail communications. I understand that CDP will make every effort to balance keeping my medical information private while still communicating needed medical information. I do not hold CDP or staff liable if my information is accessed by parties other than myself.

______________________________ ______________________________

Signature of Responsible Party Witness

______________________________ ____________________

Printed Name of Responsible Party Date

____

Relationship to Patient

Patient Name: ______________________________

PATIENT FINANCIAL POLICY

In order for us to provide quality medical care we ask that you take the time to understand your responsibility as it relates to our policies regarding financial responsibility. If you have any questions regarding this, we will be glad to assist you.

INSURANCE

We are a participating subspecialty provider in the following plans:

- Blue Cross Blue Shield of North Carolina & subsidiaries
- Aetna
- CIGNA
- Medicaid – existing patients only.
- Note: we are not in-network with any exchange policies.

It is your responsibility to know your insurance benefits. This is a contract between you and your insurance company and we cannot always accurately predict which services will be covered. In the event that we do accept assignment of benefits from your insurance company please be aware that some of the services we provide may be non-covered services. You will be 100% responsible for these charges. Most notably, your policy may not cover testing and rating scales that Dr. Moran must perform in order to assess the patient. This may include but is not limited to the following CPT codes: 96103; 96130; 99354 and even in some cases 99215 or 99245. If you have any doubt, please ask prior to arranging the appointment. We expect you to:

1. Check that Dr. Moran is covered by your insurance carrier at the location on this letterhead.
2. Be aware of your specific covered benefits prior to receiving services.
3. Check that all pre-approval requirements are met to avoid denials.

We must have accurate billing information at each visit in order to process claims according to your insurance plan's guidelines, therefore we will ask you for insurance cards at each appointments. If you fail to provide accurate information to process your claim, you will be held responsible for the charges.

Telehealth – Due to COVID, in-network insurers are now accepting telehealth appointments as fully covered visits. At a telehealth visit you will receive the same care and professional expertise that you would get at an in-office visit.

PAYMENT

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE, this includes all co-pays and deductibles. In the event that your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for all charges incurred. We accept: Cash, Checks and Credit Cards (MasterCard, Visa and Discover). In the event of overpayment on your account, overpayments of greater than $50.00 will be sent to you. Overpayments of $ 50.00 or less will be held in your account and will be credited to your next visit. Please note there is a $**50.00 returned check fee.**

____________________ Parent Initials ____________________ Date

UNPAID BALANCES

Payments not received in 60 days may be transitioned to patient responsibility and you may be required to make other payment arrangements. Any balance not paid after 90 days may be turned over to a collection agency and the patient shall be transitioned to inactive status until all obligations are met. We shall be entitled to reasonable attorney fees and court cost should litigation ensue in order to collect for unpaid bills.

MISSED APPOINTMENTS

Since we typically schedule considerable time for initial and follow-up visits, our policy is to charge **$75.00 for missed appointments** unless canceled at least 24 hours in advance. There may be an additional fee for extended testing sessions. We cannot file this with your insurance plans as they will not pay for this. Please help us by keeping, or canceling in advance, any appointments you schedule.

PHONE APPOINTMENTS

Our practice provides certain types of basic telephone care free of charge to answer routine questions regarding medication dosage, side effects, follow-up on lab results, referrals or general questions that can be answered through our regular support staff. However, on occasion there is a need for further care through telephone calls or e-mail communication which is more complicated and involves physician or nurse time, expertise and documentation of the care delivered. These types of communications are billable medical encounters and will be charged according to the following schedule:

MD Phone/ E-mail Care

5 min or less . . . No Charge

Up to 10 min . . . $50.00*

11-20 min $75.00*

21-30 min $125.00*

* Please be advised that the billable time includes both the phone/e-mail encounter PLUS documentation time. **Should your needs require phone/email consultation from the MD, the staff will secure credit card information and charge accordingly after the encounter.**

FORMS, LETTERS , REPORTS & RECORDS

Please be advised that forms, letters and reports are outside the scope of most regular appointment visits and a fee may be charged for these services according to the following schedule:

Parent Request for Records . . . . $25.00 (shipping charges may be added)

Please note: we will fax records to your designated physician without charge.

School/ Medical or Other Forms $25.00

School, Diagnosis, Legal Letters . . . . $25.00 - $50.00 depending on complexity

Testing Reports, Summary Report . . . . $50.00 - $75.00 depending on complexity

Thank you for taking the time to read and understand this Financial Policy. Please let us know if you have any questions.

I have read and agree to this Financial Policy:

___________________________________ Signature of Responsible Party

___________________________________ Printed name of Responsible Party

___________________________ Witness

_________________ Date