HIPAA Notice of Privacy Practices:
Your privacy and confidentiality are of the utmost importance to us and we are required by law to safeguard general and health related information about you. By signing below, you understand and agree to our Notice of Privacy Practice, which is available to you on our website, oncall-peds.com, or by email request to info@oncall-peds.com. **You also agree to receive updates, including but not limited to lab results and information about your treatment plan, via text message or other non-HIPAA compliant platforms, unless you have indicated otherwise**. This includes consent to transmit protected health information about me/my child via voicemail. Additionally, you understand that multiple PediatriCare team members may be involved in your/your child's care and that your/your child's information may be shared between them, when necessary.

Consent to Treat and Bill Insurance:
I give permission for PediatriCare/Samuel Moshe Singer and others to provide all medical services, including evaluation, testing and treatment to me/my dependent in person and/or via Telemedicine. Included in this consent is consent and authorization to photograph me/my child and or parts of my/my child's body for purposes of diagnosis and treatment. Furthermore, I allow PediatriCare/Samuel Moshe Singer to submit claims to insurance in order to receive payment for the care that I/my dependents receive. I understand that PediatriCare/Samuel Moshe Singer may need to send medical records to the insurance company and to third-party billing companies. I authorize my insurance carrier and/or any other health/medical plan that I may have to issue payment directly to PediatriCare LLC/Samuel Moshe Singer for medical services rendered. I understand that I am responsible for any charges that are not covered by insurance. Cost of services will vary based on presentation and findings however a good faith estimate of expected charges is available at oncall-peds.com or by email request to info@oncall-peds.com.

Patient Financial Responsibilities:
You are responsible for the payment for your/ your child's treatment and care, including your copay, deductible, coinsurance and any and all charges not covered by your insurance company.
·   Our autopay policy requires that a current credit/debit/HSA/FSA card be provided and stored in a safe, encrypted platform, following all privacy and security regulations. Your card will be automatically charged for all fees that your insurance company deems as patient responsibility.
·   We will bill services for our contracted insurers. You are required to present your insurance card and photo ID at the time of service, inform us as soon as possible if your insurance carrier changes and provide us with a copy (front and back) of your new card.
·   We will bill according to insurance guidelines for calls, patient-initiated portal consultations, and after hours, weekend, and appointments on federal holidays. Benefits related to this service vary by insurance company.
·   Patients may incur, and are responsible for the payment of additional charges at the discretion of PediatriCare. These charges may include (but are not limited to):
     o Charge for processing of co-pays received after your visit
     o Charge for returned checks
     o Charge for missed appointments without 24 hours advance notice
     o Charge for the copying and distribution of patient medical records
     o Charge for form completion

Divorced Parents:
PediatriCare will not get involved in disputes involving or related to divorced parents of a patient. The parent who is the guarantor is the responsible party for payment of services rendered. Although a divorce decree may state that an ex-spouse/partner is responsible for medical bills, PediatriCare has no authority to enforce compliance or to act as a mediator between the parties.

Consent will be considered valid unless it is voided by one of the involved parties.

_____   _____ _____   _____
Patients' Name   Guardian Name   Signature   Date

_____
E-Mail Address