PEDIATRICARE

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Oncall-peds.com

Consent to Treat and Bill Insurance
I give permission for PediatriCare 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 to submit claims to insurance in order to receive payment for the care that I/my dependents receive. I understand that PediatriCare 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 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.

HIPAA Notice of Privacy Practices and Consent for Communication
Privacy and confidentiality are of the utmost importance to PediatriCare and all staff are required by law to safeguard general and health related information. By signing below, I understand and agree to the Notice of Privacy Practice, which is available at oncall-peds.com or by email request to info@oncall-peds.com. Additionally, I understand that multiple PediatriCare team members may be involved in my/my child's care and that my/my child's information may be shared between them, when necessary.

Additionally, I understand that text messages and email are not always secure methods of communication. I consent to receive health related information, including appointment reminders, lab results, and information about my treatment or my child's treatment, by text message and/or email. I understand that I may revoke this consent or request alternative communication methods at any time by notifying the practice, and that such revocation will apply prospectively.

By providing my mobile phone number, I expressly consent to receive text messages from PediatriCare and its care team at the number provided, including messages sent using automated or electronic systems, for purposes such as appointment reminders, care coordination, and treatment related communications. I understand that consent is not a condition of receiving care and that I may revoke my consent at any time by replying STOP, by notifying the practice, or by any other reasonable means. Revocation will apply prospectively.

I consent to receive email communications from PediatriCare regarding my care, appointments, and practice related updates. I understand that I may opt out of non essential email communications at any time by following the unsubscribe instructions in the email or by contacting the practice, and that such opt out will be honored promptly.

Patient Financial Responsibilities
I am responsible for the payment for my/my child's treatment and care, including my/my child's copay, deductible, coinsurance and any and all charges not covered by my/my child's insurance company.

- PediatriCare's 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. My card will be automatically charged for all fees that my/my child's insurance company deems as patient responsibility.
- PediatriCare will bill services for its contracted insurers. I am required to present my/my child's insurance card and photo ID at the time of service, inform PediatriCare as soon as possible if my/my child's insurance carrier changes and provide PediatriCare with a copy (front and back) of my/my child's new card.
- PediatriCare 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):
    - Charge for processing of co-pays received after my/my child's visit
    - Charge for returned checks
    - Charge for missed appointments without 24 hours advance notice
    - Charge for the copying and distribution of patient medical records
    - 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.

Authorization to Share Information with Family Members and Caregivers
I authorize PediatriCare and its providers and staff to communicate with and disclose relevant health, scheduling, billing, and care related information about me/my child to my family members, caregivers, or school or residential staff (including parents, grandparents, guardians, spouses, or dorm counselors), as reasonably necessary for care coordination, unless and until I notify the practice in writing that I wish to restrict or revoke this authorization.

This Consent will be considered valid unless it is voided by one of the involved parties and can be voided at any time.

_____ _____ _____
Patient Name Guardian Name Signature

E-Mail Address _____ Date _____