Airway Pediatrics
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Welcome to Airway Pediatrics!
Office Policies, Consent to Treat and HIPAA Notification

- Patients must arrive 15 minutes before their scheduled appointment time and provide their insurance card, photo ID and insurance copay if applicable at check-in. We have a contractual obligation to your insurance company to collect copays at time of service. Copays not paid at the time of service will be assessed a $20.00 fee.
- Any outstanding balances due to deductibles, co-payments, and services not covered by your insurance are your responsibility. All balances must be paid promptly. If you are unable to pay the balance in full, please contact our office to make payment arrangements. Non-payment of charges will result in the account being turned over to a collections agency and your family will be discharged from the practice.
- We understand that patients may experience unforeseen delays while traveling to the clinic for a scheduled appointment, and we will do our best to try and accommodate. However, patients arriving more than 10 minutes late have essentially missed their appointment time. We will do our best to try and accommodate late patients by offering the option of either being seen later that day (if the schedule permits) or rescheduling for a later date. This process helps ensure that patients who arrive on time are seen in a timely manner.
- Patients may need to cancel or reschedule appointments from time to time. As a courtesy, patients are asked to contact the office 24-hours in advance if they need to cancel or reschedule their appointment. This enables us to offer the appointment time to another child in need of our healthcare services. A missed appointment is a patient who fails to appear for a scheduled appointment without providing a 24-hour cancellation or reschedule notice. A missed appointment is a loss for everyone. To assist our patient families in keeping appointments, Airway Pediatrics sends a reminder text message 48 hours before the patient's scheduled appointment. The text message offers the opportunity to either confirm or reschedule the appointment. Following the reminder message (or appointment confirmation), the patient is responsible for canceling or rescheduling the appointment no less than 24 hours before the scheduled appointment. If the patient's phone is "out of service" or not receiving calls, the patient is still responsible for keeping the scheduled appointment. You may also easily cancel or reschedule your appointments online through our patient portal. Patients with three (3) or more missed appointments and/or late canceled appointments may be asked to leave the practice.
- **If your child is being seen for a Well Child Check and you have other concerns that are not related to routine, wellness care, those concerns may generate other charges to your insurance.**
- Our practice is open 8:00am-5:00pm Monday-Thursday. After hours, we offer a telephone nursing line that puts you in touch with a pediatric-trained nurse. We charge $10.00 per call. Your insurance will not be billed for this fee, and it will be your responsibility.

- Please allow 48 business hours for all forms and prescription refill requests.
- Using the waiting room at Airway Pediatrics, PLLC, I hereby agree on my behalf and on behalf of the minor listed on this form to the following: I understand that the waiting room is unstaffed, and it is my responsibility to supervise the children in my care when they are playing, not the responsibility of Airway Pediatrics staff. I do not hold Airway Pediatrics or any staff member responsible for any bodily harm that may occur under my supervision.
- Animals are not allowed in the office unless they are a licensed service animal. If you plan to bring a trained service animal to your child's appointments, please provide a copy of the animal's license or certification as a registered service animal.
- Airway Pediatrics will use and disclose health information about the patient in compliance with the HIPAA Act. You are entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. You have the right to ask that some or all the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. Airway Pediatrics is not required by law to agree to such requests. Your signature below acknowledges that you are aware of your rights in accordance with HIPAA.
- Authorization To Pay Benefits to the Provider: I (the legal guardian and/or financially responsible party) hereby authorize the office of Airway Pediatrics to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to coinsurance, copayment, and unmet deductible for care rendered regardless of insurance coverage. _____ (Initial)
- Well Child Visit vs. Sick Visit: The purpose of Well Child Visit is to keep children adequately protected against diseases, address potential health concerns, and discuss normal and unusual development. A typical Well Child Visit may include, but is not limited to checking growth and development, physical assessment, immunizations, parental concerns about growth and development, nutrition counseling, physical activity counseling, and age specific exams may include- hearing and vision screening and developmental screenings, such as a questionnaire for indicators of autism. Generally speaking, there are no co-pay requirements for a Well Child Visit (this does not apply to all self-funded insurance plans). Airway Pediatrics is required, under contract with your insurance carrier, to collect co-pays if anything outside the scope of a Well Child Visit are addressed during your appointment. This may include, but is not limited to; illness, infections, medication modifications, or chronic illnesses (such as allergies, asthma, ADHD, or diabetes). Requesting or approving treatment for an acute or chronic illness during a Well Child Visit will trigger a copayment charge. Some insurance companies will not cover both visits at the same time of service; therefore, we may advise you to adjust the visit and reschedule one or the other. _____ (Initial)
- Consent to Treat: I am the parent or legal guardian for the patient listed on this form and on the patient's behalf, hereby request and consent to the child listed on this form, to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the patient's care. I understand treatment and services may include lab tests, screening tests, Diagnostic tests, and routine exams, Immunizations as recommended by American Academy of Pediatrics. _____ (Initial)

- HIPAA Notification: A copy of HIPAA Notice of Privacy Practices has been made available to me for review and I understand I may request a copy at any time. _____ (Initial)

We keep a record of the health care services we provide your child. You may ask us to see and copy that record (copy charges may apply). You may also ask us to correct that record. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

I HAVE READ AND UNDERSTAND AIRWAY PEDIATRICS OFFICE POLICIES, CONSENT TO TREAT, AND HAVE REVIEWED THE PRACTICE'S NOTICE OF PRIVACY PRACTICES (HIPAA)

I,_____, the parent or legal guardian of_____authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until it is revoked in writing by me. I acknowledge with my signature that I have read and understand the information above.

_____ _____

Parent/Guardian/Patient Signature Date