**ALL Pediatrics Financial and Operations Statement**

**Financial Policies**

ALL Pediatrics is committed to providing the highest quality health care for your child. As part of your relationship with ALL Pediatrics, a clear understanding of our financial policy is important so you will know what actions ALL Pediatrics will be taking on your behalf as well as what your financial responsibilities are.

 **Release of Medical Information**

I hereby authorize the Practice to disclose all or any part or the contents of the medical record of the patients named on this Registration Form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

**Privacy Policy**

I acknowledge that I have received a copy of the Notice of Privacy Practice for ALL Pediatrics.

**Responsibility for Payment**

ALL Pediatrics will bill your insurance for all services rendered using the insurance information you have provided**.** You are responsible for payment of all services provided by ALL Pediatrics. ALL Pediatrics requires all families to keep a credit card on file. You will receive an Explanation of Benefits from your insurance company (usually within 10 to 20 days after the date of visit) with the amount that is due. We will send an email to you 24 hours after the patient portion of the balance is posted. That email will list the balance that will be charged to the card on file in 14 days. Once we have charged your card, **we’ll send you a receipt via email.**

**Co-Payment**

Co-payment for services, in accordance with your insurance benefits, is due at the time of service.

**Assignment of Insurance Benefits**

I hereby request and authorize that any and all insurance benefits due and payable for medical services rendered to the patients(s) be paid directly to the Practice.

Your health insurance policy is a contract between you and your insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs. You are required to:

* Present your primary insurance card at the time of service
* Present a photo ID for verification of identity
* Inform us immediately if your insurance carrier changes and provide us with a copy of your new card (front and back).

**Patient Portal**

We request that parents create an account of the ALL Pediatrics Patient Portal. You will have electronic access to many aspects of your child’s care, including the ability to request prescription refills, schedule well visits, send non-urgent secure messages to your child’s PCP, print immunization records, request and download camp/school forms and updated demographic information. Our Patient Services Staff can help you set up an account for you.

**After Hours Phone Calls**

We provide after hours phone coverage through Triage4Pediatrics. When you call Triage4Pediatrics, we receive the information and it is entered into your child’s medical record. We charge a $25.00 fee to utilize the after-hours service. Many insurance companies offer a similar service at no charge.

**Virtual Visits**

Virtual visits (Telemedicine) consultations will be billed to your insurance according to the established guidelines. Benefits related to this service vary by insurance and you may be responsible for co-pay, coinsurance and deductible amounts.

**Late Policy**

 Patients are asked to arrive 10 minutes before their scheduled appointment time in order to complete the check-in process. ***Patients arriving more than 15 minutes late will be required to reschedule their appointment to the next available opening consistent with the type of appointment requested***. Only acutely ill children will be worked into the provider’s schedule later the same day.

**Divorced Parents**

ALL Pediatrics will not get involved in custodial, separation or financial disputes involving or related to divorced parents of a patient. The parent who is the guarantor for the policy covering the patient is the responsible party for payment of services rendered.

**Failure to Pay Outstanding Balance**

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid and you fail to contact our billing department to set up a payment plan, the account will be turned over to a collection agency.

**Additional Fees**

* Request for Medical Records—please see Medical Records Release Form
* Checks returned to ALL Pediatrics for “non-sufficient funds” $50.00
* Declined Credit Card on File $50.00
* School/Sports/Medication Forms that are not requested on the day of the visit $16.00
* Custom Letters $25.00
* After Hours Phone Calls $25.00
* No Show Fees
	+ $50.00 for sick visits,
	+ $75.00 for well visits
	+ $100.00 for consultations
	+ The No Show fee will be waived for Medicaid patients, however, families having a total of 3 no shows will be dismissed from the practice.
* Evening, weekend and holiday appointments $15.00\*\*

Holidays subject to this policy include New Year’s Day, Martin Luther King Day, President’s Day, Memorial Day, Independence Day, Labor Day, Columbus Day, and Veteran’s Day.

\*\*Fee is billed to insurance; patient is responsible for balance following claims adjudication.

**HIV / HEPATITIS B OR C TESTING**

 I acknowledge that I am hereby informed in accordance with Section 21.1 – 45.1 of the Code of Virginia, 1950, as amended, that if the provision of healthcare services to the registered patients(s) exposes any health care provider to the patient’s body fluids in a manner which may transmit immunodeficiency virus or HIV or Hepatitis B or C viruses, then the patient shall be deemed to have consented to testing for infection with HIV or Hepatitis B or C viruses, and to the release of such test results to the person(s) exposed, as provided by law.

**Single Consent to Share Medical Information with**

**Children’s IQ Network Providers Treating Me or My Child**

INTRODUCTION

As part of our commitment to improve the quality and the coordination of medical care for the children and patients we serve, ALL Pediatrics has elected to participate in the Children’s National Health System’s IQ Network. This innovative program is the first in the country to attempt to provide real-time coordination of care via an electronic medical record that allows an interface between your or your child’s health care provider and one of the country’s leading children’s hospitals.

This SINGLE CONSENT will allow us to share information, for example, with an ER doctor treating you or your child, or with a specialist to whom you have agreed we are to refer you or your child, so that they are able to quickly access critical information about you or your child from your medical record before beginning treatment. This should dramatically reduce the chance of medical errors, including adverse drug interactions or allergic reactions.

Your and your child’s healthcare information is encrypted (encoded) **and can be accessed only by health care providers who are caring for you or your child and have a need to know**.

As ALL PEDIATRICS is a part of the Children’s IQ Network, this written SINGLE CONSENT will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your or your child’s treatment. You do have the option to opt out of the Children’s IQ Network. If you choose to opt out, you will need to sign a separate consent form each and every time you or your child need to be seen by another member of the Children’s IQ Network other than those at ALL PEDIATRICS.

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**PATIENT RIGHTS:** I have received a copy of the **Children’s IQ Network** (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider’s records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN.

**PROTECTED DISCLOSURE OF INFORMATION:** I understand that Children's National complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's National can use private health information for my treatment or my child’s treatment as defined in the Notice of Privacy Practices. I agree to Children’s National use of de-identified health information about me or my child for appropriately reviewed and approved research and quality improvement activities.

**By signing below, you are agreeing to all polices outlined on the first two pages as well as choosing to opt in to be part of the CIQN network outlined above**.

**Signature of Parent/Legal Guardian/Patient (over the age of 18)**