Consent to Treat and Financial Responsibility

CONSENT TO MEDICAL CARE:
By my electronic signature below, I warrant that I am the parent, legal guardian, or have the written consent of the parent or legal guardian of the registered child(ren) named in this electronic medical record. I hereby request and authorize the physician and other health care providers of Pediatric Care of Ogden ("the Practice") and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) that have brought about my seeking medical care services for my child(ren) at the offices of the Practice. I understand that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of the Practice.

RELEASE OF MEDICAL RECORD INFORMATION:
I hereby authorize the Practice to disclose all or any part or the contents of the medical record of the patients named in this electronic medical record 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.

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.

PRIVACY POLICY ACKNOWLEDGMENT:
I acknowledge that I have received a copy of the Notice of Privacy Practice for Pediatric Care of Ogden.

FINANCIAL AGREEMENT AND GUARANTEE:
By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of __18__% per annum (__1.5__% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, interest, court costs, reasonable attorney's fees, and certified mail fees, I will also be responsible for a collection fee of up to __25__% of the principal amount(s) owing as allowed by Utah Code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.
I further acknowledge, understand and agree, that in the event that I fail to make such payments in accordance with the payment policies of the Practice, or in the event of default of my financial obligation to pay for services rendered, the Practice may terminate the "doctor-patient" relationship with the registered patient(s) in accordance with the Code of Utah.

CORRECT INFORMATION:
The undersigned certifies that he/she has provided correct information and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal guardian, duly authorized to execute the above and to accept its terms.

PEDIATRIC CARE OF OGDEN

OFFICE VISITS: are by appointment only. Walk-ins are not given priority over parents who call for appointments per our policy.

LATE POLICY: Patients arriving 20 minutes or more 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.

CANCELLATION POLICY: As a courtesy to both your provider and other families with sick children, we ask that you cancel any scheduled appointment 24 hours in advance so that others may utilize this time. Failure to attend an appointment without prior cancellation is considered a NO SHOW. NO SHOWS are charged to the patient at $35.00 per missed visit.

CO-PAYS: must be paid at the time of each visit. This is the policy of your insurance company, which our office is required to comply with. If you fail to pay your co-pay, If you fail to make your co-pay at the time of service there will be a $5 charge in addition to the co-pay.

PRESENT A VALID INSURANCE CARD AT EACH VISIT: If you request that we bill your insurance for your child(ren)'s care, you must present a valid insurance card at each visit. Failure to present a valid card may result in your being required to make a $50.00 deposit as a self-pay patient for that visit.

CHILDREN UNDER 18 MUST HAVE A PARENT / GUARDIAN PRESENT:
Children under the age of 18 cannot legally consent to their own treatment. Treatment can only be approved by a parent or legal guardian. If you cannot attend their appointment and must send your child(ren) alone, or with an older sibling, grandparent, or nanny, please be aware that they have no legal authority to provide a "consent to treatment" for your child. You must send a SIGNED LETTER OF AUTHORIZATION WITH THEM, or give us written pre-authorization naming the person(s) you approve in advance to consent to treatment on your behalf. If you wish to do this, please request a PRE-AUTHORIZATION FORM from our front desk staff.

Patient Name _____

Patient Date of Birth_____ / _____ /_____

Responsible Party Name _____

Signature_____ Date_____/_____/_____