Eastman, Wozniak, Groebe Pediatrics, P.C.
2055 E 14 mile Rd, Birmingham, MI 48009

PLEASE ADD THE NAMES OF ALL CHILDREN

Childs Full Legal Name _____ Birthdate_____ Gender: F M

Childs Full Legal Name _____ Birthdate_____ Gender: F M

Childs Full Legal Name _____ Birthdate_____ Gender: F M

Childs Full Legal Name _____ Birthdate_____ Gender: F M

Child's Race (Circle): African American Asian Caucasian Hispanic Middle Eastern Other_____

Child/Children reside with _____

Primary email _____

Primary Phone # _____ cell or home

Parent Name _____ **Relationship to child** _____

Birthdate _____ SS Number _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Employer _____

Parent Name _____ **Relationship to child** _____

Birthdate _____ SS Number _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Employer _____

Primary Insurance _____ Name of Subscriber _____

Secondary Insurance _____ Name of Subscriber _____

Emergency Contact (other than parent) _____

Phone # _____ Relationship to Child _____

Signature _____ **Date** _____

Updated: (initial and date) _____

Consent to Examine and Treat a Minor

- I do hereby consent and authorize Eastman, Wozniak, Groebe Pediatrics, P.C., and/or such associates, assistants or designees, to examine and treat my child/children:
- _____
- I affirm that I have the legal right to consent to this.
- This consent is binding until specifically revoked by myself or another person who has the right to sign or revoke this form.
- I give the physicians of Eastman & Wozniak, MD, PC permission to treat my child in my absence in case of emergency or when accompanied by a designated representative.

Payment and Office Policies

I authorize the release of any medical records to process insurance claims on my behalf. I agree to be fully responsible for all lawful debts incurred for medical services by Eastman, Wozniak, Groebe Pediatrics, P.C. whether covered by my insurance or not. I understand that I am responsible for knowing my insurance benefits and notifying us of any restrictions or maximums. We will verify that your insurance is in effect, but we can not verify what your benefits are. Verification goes not guarantee payment. Your insurance is a contract between you and your insurance company.

Copays must be paid at the time of the visit. For minors, payment is expected to be made by the parent/guardian who brings the child to the appointment at the time of service. We will gladly furnish you with necessary statements for reimbursement. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. If you are experiencing financial difficulties please discuss this with our billing department. We are happy to work with you to arrange a payment plan that will work in your budget. Accounts over 60 days past due may be referred to a collection agency.

Insurances/HMO/POS/PPO
I understand that due to the uncertainty of eligibility and/or primary care physician assignment, that **if denied by insurance for services or treatment, I am financially responsible for all balances**. This includes all HMO plans. **I understand that the assignment of a Primary Care Physician to an Eastman & Wozniak Physician is my responsibility.** If your insurance is a HMO and your child requires services by a specialist, adequate planning is essential. Referrals must be authorized by your physician and usually requires an office visit.

Please be advised that there will be a $5.00 rebilling fee for any uncollected balance if we have not received a response from the first bill sent.

We will attempt to contact you 1-2 business days prior to your appointment as a reminder. If we are unable to reach you, it is still your responsibility to keep your appointment. We would greatly appreciate 24 hour notice for all cancellations.

Newborns
I understand that it is my responsibility to contact my insurance to have my newborn child added to my insurance within the first week of life. I understand that failure to do so may jeopardize my child's ability to be insured. I will provide Eastman, Wozniak, Groebe Pediatrics, P.C. with my child's health care coverage information as soon as the policy is effective to assure timely billing. Failure to do so will result in non-covered services by my insurance to which I am responsible for and guarantee payment. If you receive a bill from our office, please verify that the child has been added to the policy and call our billing department for the charges to be billed to your insurance. Please ask to speak to the billing department if you have any questions.

I understand and accept the above statements:

_____ _____
Signature of Parent/Legal Guardian Date

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgement ". Please note that by signing the Acknowledgement Form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgement

I have read the above HIPAA Privacy Policies. As indicated above, I know my rights as a patient and also know and agree to the policies and procedures set in place by Eastman, Wozniak, Groebe Pediatrics, P.C.

Signature _____ **Date** _____

Please list ALL children under the age of 18 that are patients of the practice:

Child's Full Name: _____

_____

_____

_____

I request the following person(s), **other than the parent or guardian**, to receive information regarding the above named minor, child children(s) protected health information:

Name:_____ Relation:_____ Birth Date:_____

Name:_____ Relation:_____ Birth Date:_____

Name:_____ Relation:_____ Birth Date:_____

Eastman, Wozniak, Groebe Pediatrics, P.C.

2055 E 14 Mile Road, Birmingham, MI 48009 Phone: (248) 645-1740

Financial Agreement

1. Payment is expected at the time of service. This includes all co payments, deductibles and non covered services. It is important to know what your insurance plan covers. Services not covered by your insurance company are your responsibility.

   Copays are required to be paid at the time of service per your insurance company. We are required to follow the contracts we have with the insurance carriers to abide by this rule. Please be advised that we need to collect the copays, at the time of service regardless of who is bringing in the child to avoid a billing fee to be added to your account.

   Please be aware of specific details of your insurance plan's covered benefits. This is especially important with regard to deductibles, and non covered services performed in the office. Many of the insurance carriers are not covering labs and tests done here in the office. We verify eligibility however we are unable to verify what each families benefits are. It is the parent or guardian's responsibility to know what is covered on their families plan. It is your responsibility to know the limitations of your coverage and to communicate them with our office staff prior to delivery of services.

2. If your insurance is a Managed Care Plan (HMO) and your child requires services that require a referral, adequate planning is essential. Referrals must be authorized by your Physician and usually requires an office visit. Once the Physician approves the referral, your insurance carrier must also approve it. Authorization from insurance plans can take up to one week. Please be aware that we may not be able to accommodate same day call in requests for referrals. Upon receipt of a referral to a specialist or ancillary service it is your responsibility to be aware of what has been authorized. Subsequent visits, procedures, surgeries and hospitalization typically require additional referrals. Failure to obtain necessary authorizations often leads to out of pocket expense. We are happy to assist you in any way with your managed care plan.
3. If you can not provide adequate proof of insurance, you will be responsible for the entire visit at the time services are rendered. **In order for us to bill your insurance carrier we must have a copy of your insurance card, front and back.**
4. As per insurance carrier guidelines we charge an additional fee of $30.00 for after hours non routine care provided in our office on weekends, evenings or holidays. This fee may or may not be covered by your insurance carrier.
5. In the case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered regardless of coverage or insurance arrangements. We will gladly furnish you with necessary statements for reimbursement.
6. If a payment plan is necessary we are happy to work with you to arrange a plan that will work within your budget. Accounts over 60 days past due may be referred to a collection agency.

I understand and accept the above statements. Please sign, date, and print the name of each child:

Parent/Guardian Signature and date:_____

Children(s)names:

_____

_____

_____

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