Annual Consent and Acknowledgment Form

This form is to be completed annually for Advocare LLC and scanned into each Patient's File

Patient Name: ______________________________ DOB: ______________

Address: ____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

Advocare and its parent, affiliates, associates, agents, services, debt collectors, independent contractors, assigns, successors, subsidiaries and employees (defined here collectively as "ADVOCARE" and referred to as "ADVOCARE" or "we") provide healthcare services (referred to collectively as the "Services"). By using the Services or accessing your account, any recipient of the Services accepts and also agrees to be legally bound by the terms of this Agreement to the extent permitted by law.

General Consent for Examination and Treatment

I hereby consent and authorize Advocare and all its physicians and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which my specific informed consent is not otherwise required. This consent includes consent and authorization to photograph or otherwise take images of me for purposes of identification, diagnosis, treatment, payment and healthcare operations. Any photographs or other images taken will become part of my medical record. Advocare will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advocare will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of Advocare's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advocare has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, Advocare will post a new notice in its offices. I may contact Advocare at any time to obtain a current copy of the Notice of Privacy Practices. I may also access a copy on the Advocare website at www.advocaredoctors.com

Assignment of Benefits/Authorization/Notice of Collection

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles and charges denied by my insurance company as not covered or not medically necessary. You agree to reimburse Advocare the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt added to the debt at the time it is placed with the agency for collection, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Consent to Contact

You expressly authorize, and specifically consent to allowing, ADVOCARE and/or its outside collection agencies, outside counsel, or any other agents acting by or on behalf of ADVOCARE to contact you or any recipient of the Services with informational messages regarding your account, including but not limited to contact in connection with any and all matters relating to unpaid past due charges billed to you. You agree that such contact may be made to any mailing address, telephone number, cellular phone number, e-mail address, or any other electronic address that you or a recipient of the Services have provided, or may in the future provide, to ADVOCARE and to any and all telephone numbers billed on your account or any number where you or a recipient of the Services can be reached by ADVOCARE. You expressly consent and agree that such contact may be made using, among other methods, pre-recorded, artificial voice, or other message delivered by any type of telephone equipment including a dialer, automatic telephone dialing system, predictive dialer, interactive voice recognition system, or text message delivered by an automated system, pre-set e-mail messages delivered by an automatic e-mailing system, or any other pre-set electronic messages delivered by any other automatic electronic messaging system, including numbers assigned to any paging, cellular or mobile service, even for any service for which you are charged for the call or contact. Carrier message and data rates may apply. You agree to provide true, accurate, current and complete contact information about yourself and any recipient of the Services to ADVOCARE and its authorized agents and to promptly update this contact information to keep it true, accurate and complete. If you do not want ADVOCARE to use these telephone contact methods to reach you or a recipient of the Services, please contact us at 856.221.2700 to discuss how we may communicate about this account

Vaccine Registry (if applicable)

Our office submits confidential data of children and adult vaccinations to your state's Immunization Registry as permitted by state law. The purpose of this registry is to keep a central record of patients' immunization history.

Disclosures to Authorized Individuals

I designate the following person(s) listed below as a person(s) involved with my medical treatment and/or payment for my medical treatment. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. A copy of the authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Name: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

Medical Treatment Information: Yes No Payment Information: Yes No

Name: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

Medical Treatment Information: Yes No Payment Information: Yes No

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed? ☐ Y ☐ N

Do you or your spouse have other insurance? ☐ Y ☐ N

Are you disabled or have end stage renal disease? ☐ Y ☐ N

Is illness/injury the result of an auto accident? ☐ Y ☐ N

Did illness/injury occur at work? ☐ Y ☐ N

Has treatment been authorized by the V.A.? ☐ Y ☐ N

Are you covered under the Black Lung Program? ☐ Y ☐ N

Is there Medigap coverage secondary to Medicare? ☐ Y ☐ N

Is there insurance coverage primary to Medicare? ☐ Y ☐ N

Is there employer supplemental coverage secondary to Medicare? ☐ Y ☐ N

Consent and Authorization

A copy of this consent and acknowledgment may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my PHI and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: ______________________ Date: ______________

Patient Signature: ______________________

Legal Representative (if other than patient) Print Name: ______________________ Date: ______________

Legal Representative Signature: ______________________ Relationship to Patient: ______________

☐ New Patient ☐ Edit Information

Child Registration Form

This form can be used for all children UNDER the AGE of 18

Please complete this form to ensure proper billing of your services. **Please Print.** Today's Date:________________

Patient Information

Patient Last Name ______________________ First ______________________ MI ________

Preferred Name: ______________________________ Date of Birth ________________

Minor's Cell Phone ______________________

Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Declined to specify

Race:

☐ American Indian/Alaska Native ☐ Asian

☐ African American ☐ Native Hawaiian/Pacific Islander

☐ White ☐ Declined to specify

Preferred Language: ☐ English ☐ Spanish ☐ Other ________ **Translator?** ☐ YES ☐ NO Comments: ______________

Primary Care Provider:

Name: ______________________

Address: ______________________

____

City, State, Zip: ______________________

Phone: ______________________

Fax: ______________________

Referring Provider:

Name: ______________________

Address: ______________________

____

City, State, Zip: ______________________

Phone: ______________________

Fax: ______________________

Patient's Primary Address

Address: ____

City, State, Zip: ____

Home Phone: (_______) ____

Patient's Reminders/Communication

This section is related to communication and Patient Portal access (See 'Patient Portal FAQs')

Please provide the contact information for the person who is to receive the reminders/communication for this patient.

Home Phone: (_______) ________________ Cell Phone: (_______) ________________ Work Phone: (_______) ________________

☐ Web Enabled Patient E-Mail: ______________________________________
(must be patient's email if over age 12)

☐ No Email ☐ Patient Refused Parent/Proxy E-Mail: ______________________________________

☐ Voice Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

☐ Text Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:

☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ **ALL** ☐ **NONE**

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #:_______________

Patient's Parental Information

Patient lives with ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian*
Custody Agreement ☐ YES ☐ NO ☐ N/A (If YES, please provide copy)

Mother's Name: _______________
Cell Phone: _______________
Mother Address same as patient ☐ YES ☐ NO
If NO- please complete
Addr: _______________
City, State, Zip: _______________
Mother's Date of Birth: _______________
Home phone: _______________
Email Address: _______________
Employment Status:
☐ Employed FT ☐ Employed PT ☐ Not Employed
☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt
Employer: _______________

Other please explain: _______________
*If YES to Guardian, please provide court documents

Father's Name: _______________
Cell Phone: _______________
Father Address same as patient ☐ YES ☐ NO
If NO- please complete
Addr: _______________
City, State, Zip: _______________
Father's Date of Birth: _______________
Home phone: _______________
Email Address: _______________
Employment Status:
☐ Employed FT ☐ Employed PT ☐ Not Employed
☐ Self ☐ Active Military ☐ Retired ☐ Reserved - Nat'l assignmt
Employer: _______________

Emergency Contact Information

(please provide contact other than parents)

Last Name, First Name: _______________ Relationship to Patient: _______________
Home Phone: (____) _______________ Cell Phone: (____) _______________ Work Phone: (____) _______________

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance
☐ Self-Pay (no insurance) Patient insured under: ☐ Mother's Insurance ☐ Father's Insurance ☐ Other
☐ Medicaid – ID Number: _______________

PRIMARY INSURANCE NAME:
Benefit Plan Name _______________
Member ID: _______________ Group#: _______________ Effective Date: _______________
Subscriber's Name: _______________ Subscriber's DOB: _______________
Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
PCP listed on card: _______________

SECONDARY INSURANCE NAME:
Benefit Plan Name _______________
Member ID: _______________ Group#: _______________ Effective Date: _______________
Subscriber's Name: _______________ Subscriber's DOB: _______________
Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
PCP listed on card: _______________

Guarantor Information

Guarantor must initial to acknowledge that you are aware that you will receive the bill and be financially responsible for this patient. Guarantor Initial: _______________

Relationship: ☐ Father ☐ Mother ☐ Other (specify): _______________
Last Name: _______________ First Name: _______________
Date of Birth: _______________ Gender: ☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F ☐ Decline to specify
Address: _______________
City, State, Zip: _______________
Home phone: _______________ Cell Phone: _______________ Email: _______________
Guarantor's Employer: _______________
Work phone: _______________
Address: _______________
City, State, Zip: _______________

745 Northfield Avenue, Suite 7
West Orange, NJ 07052
Phone: 973.243.0002
Fax: 973.243.1227

7 James Street
Florham Park, NJ 07932
Phone: 973.295.6226

HOUSEHOLD:

PLEAST LIST ALL THOSE LIVING IN THE CHILD'S HOME.

NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:
NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:
NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:
NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:
NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:
NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:
NAME:	RELATIONSHIP:	DOB:	HEALTH PROBLEM:

BIRTH HISTORY:

BIRTH WEIGHT: DELIVERY: VAGINAL OR CESAREAN

WAS THE BABY BORN: TERM? EARLY? LATE?

IF CESAREAN, EARLY OR LATE, PLEASE EXPLAIN WHY

DID YOUR BABY HAVE ANY PROBLEMS AFTER BIRTH?

DID MOTHER HAVE ANY ILLNESS OR PROBLEMS DURING PREGNANY? YES OR NO

DURING PREGNANCY, DID MOTHER SMOKE OR DRINK ALCOHOL? IF YES, PLEASE EXPLAIN:

WAS INITIAL FEEDING: BREAST OR BOTTLE

DID THE BABY GO HOME WITH MOTHER FROM THE HOSPITAL? YES OR NO, IF NO PLEASE EXPLAIN:

GENERAL:

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? YES NO, EXPLAIN:

DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITION? NO YES, EXPLAIN:

HAS YOUR CHILD HAD SERIOUS INJURIES OR ACCIDENTS? NO YES, EXPLAIN:

HAS YOUR CHILD HAD ANY SURGERY? NO YES, EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED? NO YES, EXPLAIN:

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS OR DRUGS? YES NO

IF YES, WHICH DRUGS:

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FAMILY HISTORY:

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING? PLEASE CIRCLE (YES) OR (NO)

DEAFNESS:	YES	NO	WHO:
NASAL ALLERGIES:	YES	NO	WHO:
ASTHMA:	YES	NO	WHO:
TUBERCULOSIS:	YES	NO	WHO:
HEART DISEASE: (BEFORE 50 YEARS OLD)	YES	NO	WHO:
HIGH BLOOD PRESSURE: (BEFORE 50 YEARS OLD)	YES	NO	WHO:
HIGH CHOLESTEROL:	YES	NO	WHO:
ANEMIA:	YES	NO	WHO:
BLEEDING DISORDER:	YES	NO	WHO:
LIVER DISEASE:	YES	NO	WHO:
KIDNEY DISEASE:	YES	NO	WHO:
DIABETES:	YES	NO	WHO:
BED-WETTING: (AFTER 10 YRS OLD)	YES	NO	WHO:
EPILEPSY:	YES	NO	WHO:
CONVULSIONS:	YES	NO	WHO:
ALCOHOL ABUSE:	YES	NO	WHO:
DRUG ABUSE:	YES	NO	WHO:
MENTAL ILLNESS:	YES	NO	WHO:
MENTAL RETARDATION:	YES	NO	WHO:
IMMUNE PROBLEMS: (HIV OR AIDS)	YES	NO	WHO:

I, the undersigned, give my authorization to treat and assign directly to Kintiroglou Pediatrics, all medical benefits if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not be paid by insurance. I authorize the doctor to release all information necessary to secure that payment benefits. I authorize that use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I also understand that there are administrative fees that I might incur related to non-direct medical care such as school forms, copy of charts, missed appointments, etc. I will be responsible for any bills that incur if insurance is terminated, rebilling fees related to this or any bill, as well as any collection, court costs and improper scheduling of check-ups.
I AUTHORIZE THE PRACTICE TO USE AND DISCLOSE MY HEALTH INFORMATION FOR PURPOSES OF TREATING PATIENT, OBTAINING PAYMENT FOR SERVICES RENDERED TO ME AND CONDUCTING HEATHCARE OPERATIONS. I ACKNOWLEDGE THAT THERE IS A COPY OF THE HIPPA PRIVACY PRACTICES NOTICE POSTED IN THE OFFICE.

PARENT/GUARDIAN SIGNATURE SIGNATURE DATE

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ADVANCE BENEFICIARY NOTICE (ABN)

TRANSCUTANEOUS BILIRUBINOMETRY
(BILICHECK)

$30.00

Your health insurance may not pay for the cost of CPT Code: 88720. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service.

PARENT/GUARDIAN SIGNATURE DATE OF SIGNATURE

SPOT VISION TEST
(AUTOMATED EYESCREENING)

$25.00

USUALLY RECOMMENDED AT THE 12, 24, AND 26 MONTH WELL VISITS FOR VISION TESTING.

Your health insurance may not pay for the cost of CPT Code: 99174. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service.

PARENT/GUARDIAN SIGNATURE DATE OF SIGNATURE

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PRACTICE HEALTH INFORMATION AUTHORIZATION

Persons/Organizations authorized to use of disclosed information: C&M Kintiroglou, M.D., PA

I hereby authorize the use and disclosure of my individually identifiable health information. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: ____ Date of Birth: _______________

1. I understand that the practice is given 30 days for Medical Records to be copied if patient is leaving the practice.
2. I understand that I may get a copy of this form after I sign it.
3. I understand that I may revoke this authorization at any time by notifying the Practice in writing. If I do, the revocation will not have any effect on actions the Practice has already taken in reliance on this authorization.

PARENT/GUARDIAN SIGNATURE DATE OF SIGNATURE
____

____
PRINT NAME OF PATIENT

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ROUTINE CHECK-UP AND IMMUNIZATION SCHEDULE
SUGGESTED BY OUR PRACTICE AND THE AMERICAN ACADEMY OF PEDIATRICS:

2 WEEKS
1 MONTH
2 MONTHS: FIRST IMMUNIZATION SCHEDULE
1. PEDIARIX: (DTaP, Hep B & Polio)
2. HIB #1
3. PREVNAR 13 #1
4. ROTAVIRUS #1

4 MONTHS: SECOND IMMUNIZATION SCHEDULE
1. PEDIARIX: (DTaP, Hep B & Polio)
2. HIB #2
3. PREVNAR 13 #2
4. ROTAVIRUS #2

6 MONTHS: THIRD IMMUNIZATION SCHEDULE
1. PEDIARIX: (DTaP, Hep B & Polio)
2. HIB #3
3. PREVNAR 13 #3

9 MONTHS: NO IMMUNIZATION SCHEDULED

1 YEAR: FOURTH IMMUNIZATION SCHEDULE
(MUST BE AFTER 1ST BIRTHDAY)
1. PREVNAR 13 #4
2. HIB #4

15 MONTHS: FIFTH IMMUNIZATION SCHEDULE
1. MMR #1
2. VARICELLA #1

18 MONTHS: SIXTH IMMUNIZATION SCHEDULE
1. DTaP
2. HEP A #1

21 MONTH: NO IMMUNIZATION SCHEDULED, **PLEASE CHECK WITH INSURANCE IF THIS IS A COVERED VISIT**

2 YEAR: SEVENTH IMMUNIZATION SCHEDULE
1. HEP A #2

2 ½ YEAR: NO IMMUNIZATION SCHEDULED, **PLEASE CHECK WITH INSURANCE IF THIS IS A COVERED VISIT**

3 YEAR: NO IMMUNIZATION SCHEDULED

4 YEAR: EIGHTH IMMUNIZATION SCHEDULE
(MUST BE AFTER 4TH BIRTHDAY)
1. KINRIX: (DTaP & Polio)
2. MMR #2
3. VARICELLA #2

*YEARLY ANNUAL EXAM THEREAFTER

11 YEAR: NINTH IMMUNIZATION SCHEDULE
(OR BEFORE GOING INTO 6TH GRADE)
1. BOOSTRIX (Tdap)
2. MENVEO #1 (MENINGOCOCCAL)
3. GARDASIL: Office visit is billed and co-pay may be patient responsibility.

*YEARLY ANNUAL EXAM THEREAFTER

16 YEAR: TENTH IMMUNIZATION SCHEDULE
1. MENVEO #2

17 YEAR: ELEVENTH IMMUNIZATION SCHEDULE
1. BEXSERO (MENINGOCOCCAL B) – 2 doses one month apart

I, ____________________, THE PARENT OF ____________________ HAVE READ AND UNDERSTAND THE PRECEDING SCHEDULE, IF I HAVE ANY QUESTIONS OR CONCERNS I WILL DISCUSS THEM WITH THE PHYSICIAN. I UNDERSTAND THAT I HAVE A RIGHT TO SEPARATE VACCINES. **I ALSO UNDERSTAND THAT IF THE CHOICE TO SEPARATE VACCINES IS MADE WITHOUT THE RECOMMENDATION OF THE PHYSICIAN A CO-PAYMENT AND/OR DEDUCTIBLE WILL BE APPLIED TO VACCINATION VISITS.**

PARENT/GUARDIAN SIGNATURE DATE OF SIGNATURE

745 Northfield Avenue, Suite 7
West Orange, NJ 07052
Tel:(973)243-0002 Fax: (973) 243-1227
E-mail: kintirogloupediatrics@gmail.com
Office Supervisor: Kimberly Arcila

7 James Street
Florham Park, NJ 07932
Tel:(973)295-6226 Fax: (973) 243-1227
E-mail: fpkintirogloupediatrics@gmail.com
Office Supervisor: Milany Alves

UNDERSTANDING OUR POLICIES & PROCEDURES

1. **Walk-Ins:**
   a. **EFFECTIVE OCTOBER 2,2017 IN THE WEST ORANGE LOCATION:**
      i. **Monday-Friday 8am-10 am.**
      ii. Any time after those hours *must* be a **scheduled appointment.**
   b. First come-First serve
      i. If the walk-in hours are particularly busy one day, waiting times may vary. We hope to get you in and out as quickly as possible!
   c. You will be seen by the assigned walk-in provider:
      i. Not all providers are scheduled to provide sick care each day.
      ii. If you want a specific provider, you must call to make an appointment with that provider.
   d. Walk-ins are *NOT* for:
      i. Behavioral issues
      ii. Consults
      iii. Immunizations
      iv. Weight checks
   e. **WE DO NOT HAVE WALK-INS ON SATURDAYS OR IN THE FLORHAM PARK LOCATION**
      i. Please call to make an appointment.
      ii. You will be charged a **walk-in fee** on top of your copay
2. **Scheduling/Appointments:**
   a. Please make your Physical Exam appointments 3 months in advance.
      i. KEEP IN MIND, our providers book up **quick**!
      ii. Call ahead if you would like to request the provider you would like to see.
   b. All Physical Exam appointments are a **year** from the *last* physical.
      i. Please check with your insurance if you would like a sooner or different date
   c. Missed Appointments
      i. Scheduled appointments are a good faith agreement between the patient and this practice. In consideration of our patients' needs and out of respect for the doctors' time, there is a charge for missed appointments as follows:
      ii. Physical Exams not given 24 hours' cancellation notice or considered a "no show" will be billed $35.00.
   d. EFFECTIVE IMEDIATELY: If you are more than 15 minutes LATE to your physical exam appointment, you **will** be rescheduled. No Exception.
   e. Med Checks are **every 3 months**.
      i. Before you leave the office, please make sure to book your next Med Check appointment.
   f. Pre-Op appointments are to be made a day or two before the procedure date, unless said otherwise by the ordering physician.
   g. Please specify which office you would like to go to.

        i. Not all of the providers rotate, so make sure the one you are requesting is available for the day you would like.
    h. Please make sure to have all your questions in order before seeing the provider.

3. **<u>School/Camp Forms:</u>**
    a. You may E-mail, Mail-in, or Drop-off.
        i. We do not accept Faxes or Fax back.
    b. Please make note on the form of which method you would like us to return directly to you.
        i. We do not return to school/camp to prevent possibility of form getting lost in transit.
    c. Each school form is $10.00.
        i. Expedited fee is $5.00 (Total charge $15)
    d. Due to high volume of school forms we receive, it takes up to 2 weeks at most to complete the form(s).
    e. We hold completed original forms up to 30 days.
4. **<u>E-mail:</u>**
    a. *ONLY* for **document** exchange (i.e. school/camp forms, insurance cards, etc.)
    b. Any medical questions or concerns must be called into the office.
    c. We do not accept pictures or videos, unless specified by provider.
5. **<u>Returned Check Fees:</u>**
    a. In addition to the bank fee, we will impose a $25.00 returned check fee.
6. **<u>"Medicaid" Patients:</u>**
    a. The providers do not participate in any of the state Medicaid plans. If it is your primary insurance, <u>we cannot treat you here</u>.
    b. We will not honor the Medicaid explanation of benefits which says you have no financial responsibility and by signing this document you do here by agree to pay said balance.
    c. If you do not inform us at the time of service that you have Medicaid, and your claim processes as such, you will not be able to remain a patient of this practice and will be responsible for the full charges.
7. **<u>In Office Labs:</u>**
    a. There are two tests the providers may wish to perform in the office during your visit:
        i. Strep test
        ii. Urinalysis.
    b. Real time results may allow the doctor to begin early treatment for your condition.
    c. There are a small minority of Insurance plans that will not pay for these tests when done in an office setting.
        i. We do not know if your plan type is one of them, but if it is, you would receive an explanation of benefits indicating that no payment was made to the doctor and that you are not responsible for the charge.
        ii. By signing this document, you agree to waiver your coverage with regards to THAT TEST ONLY and to pay the amount billed for the test.
        iii. Each test is under $25.00.
8. **<u>Insurance/Billing:</u>**
    a. We will need insurance cards to be scanned every year regardless if it has changed or not.
    b. Please make sure your address, phone number, and/or pharmacy information is always up-to-date.
    c. If there is a question/concern/problem regarding a bill you received from us, please contact your insurance company **immediately**!
        i. If your insurance company says that it is something that we need to fix, please get a reference number and call us back.
        ii. Otherwise, these claims will become ***your*** **responsibility** due to timely filing!

By my signature, I acknowledge that I have read and understand the policies and procedures of KINTIROGLOU PEDIATRICS as defined in this packet that I received.

Print all patient names:

PARENT/GUARDIAN SIGNATURE DATE OF SIGNATURE