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# OUR OFFICE POLICY AND HIPPA DISCLOSURE

PLEASE READ CAREFULLY and ask questions if you need clarification

**Consent for Treatment:** I hereby authorize/ consent to examination and treatment of the patient by the provider and clinical staff and to performance of any surgical and/or diagnostic procedure that is deemed necessary.

**Authorization to Release Information:** I hereby authorize Carolina Pediatric Surgery to release any information, including the diagnosis and records of any treatment(s) or examination(s) rendered to me or my child, to my insurance company(s) or Worker's Compensation carrier necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or Carolina Pediatric Surgery. I also authorize Carolina Pediatric Surgery to release any information including the diagnosis and records of any treatment(s) or examination(s) rendered to my child or me to specialty physicians when necessary to assist in my treatment or care.

**Insurance:** I acknowledge that it is my responsibility to be familiar with my particular insurance plan and that the provider will be basing recommendations for my health care on my health needs, and not on insurance reimbursement. I understand that I am responsible for verifying that Carolina Pediatric Surgery or its physicians are participating with my insurance plan prior to receiving services. If my insurance plan requires pre-authorization for any services or referrals, I am responsible for ensuring that the services have been pre-approved by my insurance plan. I acknowledge that I am responsible for payment in full of any charges not covered by my insurance plan. I understand that I am responsible for payment of these charges even if they are deemed not medically necessary by my insurance. In particular, the cleft lift procedure is partially covered by some insurance plans and I will be responsible for payment of any charges not covered by my insurance. I also understand that if I do not present my insurance card at each visit, I will be responsible for payment in full for services rendered. I understand that payment for services rendered is ultimately my responsibility

**Financial Responsibility:** I understand that I am responsible for payment at the time services are rendered including previous balances, copayments, coinsurance, deductibles or services not covered by my insurance plan. I acknowledge that I have provided current and accurate insurance information to enable timely reimbursement for medical services. If insurance information cannot be verified or if I do not have health insurance coverage, I will pay in full at the time of service by credit card, cash or check. I understand that any balance after my insurance company has paid is due within 30 days of receipt of the billing statement. I understand that accounts not paid after 90 days from the date of service will be turned over to a collection agency and reported to the credit bureau.

**Cancellation Policy:** I understand that if I am not able to keep a scheduled appointment, I must notify the office at least 24 hours in advance of the appointment time. I am aware that I will be charged a $50.00 cancellation fee if I do not provide 24 hours notification or do not show for a scheduled appointment.

**Testing (Laboratory Tests, Radiology Imaging, Endoscopic Procedures, and Other Investigations):** I understand that an outside laboratory, radiology department or other facilities will be used for investigations. These facilities may process blood, urine or tissue specimens as ordered by the physician. These services will be billed separately by respective facilities. It is my responsibility to contact the lab or these facilities with any questions regarding the cost of the investigations, or if you have any questions regarding their bill.

**Minor Patients:** I understand that as the adult accompanying the minor, I am responsible for any payment amount due for services rendered regardless of the responsible party or insurance policyholder. I will be provided with a receipt for my personal reimbursement.

**Acknowledgment of Personal Property:** I understand that Carolina Pediatric Surgery shall not be liable for loss or damages of any personal property.

## HIPPA DISCLOSURE:

I authorize Carolina Pediatric Surgery personnel to leave confidential information about test results, lab reports or billing at the following number:

Please provide #_____ ☐ Home ☐ Cell ☐ Work

**(if no number is provided, we will not be able to contact you)**

Email address: _____

I authorize the persons listed below (spouse, friend, parents, etc) to receive healthcare (incl. picking up Rx's, lab reports, medical records, etc.) information on my behalf:

_____

Name Phone Relationship

Emergency Contact:

☐ Same as above

_____

Name Phone Relationship

**Limits of Confidentiality**: We are permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization: suicidal urges (being a danger to yourself), homicidal urges (being a danger to others), court order/subpoena, child abuse/neglect, and elder or vulnerable adult abuse/neglect.

I understand that I may revoke this consent in writing; however, my revocation will not apply to information already used or released in reliance on this consent. I agree that a copy of this consent may be used in place of the original. I also understand that by refusing to sign this consent or revoking this consent, this organization may not be able to provide services to me. My signature below indicates that I understand and accept the content of this form.

Signature _____ Date _____

Patient or Patient Representative (print name)_____

If not the patient: Relationship to Patient: _____