PARENTAL CONSENT TO TREAT

As parents of the minor child listed below, I/we consent to any x-ray examination, anesthetics, medical or surgical diagnostic or treatment procedures deemed necessary for the treatment by IDEAL Pediatrics medical providers.

Name	Birthdate	Allergies

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage said physicians to exercise their best judgment as to requirements of such diagnosis or treatment.

This consent shall remain effective for one year unless sooner revoked in writing and delivered to said physicians.

Dated_____

_____
Parent 1

_____
Witness

_____
Parent 2

_____
Legal Guardian or Responsible Party

_____
Street Address

_____
City State Zip

_____
Telephone Number

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

PATIENTS NAME:_____ DOB:_____

Notice of Privacy/No Show Policy Acknowledgement

I, _____, acknowledge that I have received from Ideal Pediatrics, LLC a copy of their Privacy Notice, No Show Policy (rev 04/23/2018), and Billing Policy. I understand it is my responsibility to read the notices and ask questions as necessary. I am also aware that I am responsible for all collection agency fees, as well as court costs and attorney fees, in the event of litigation, if my account is sent to collections for non-payment.

_____ **Text** _____
Patient Signature/Patient Representative Date

_____
Relationship to Patient

_____ _____
Witness Date

CONSENT FOR RELEASE OF INFORMATION TO DESIGNATED FAMILY MEMBERS OR CAREGIVER.

The Undersigned consent to Ideal Pediatrics releasing his/her medical information to: (may include but not limited to grandparents, step-parents, or other relatives.

_____
Name to Receive Info & Relationship to Patient

_____
Name to Receive Info & Relationship to Patient

_____
Name to Receive Info & Relationship to Patient

This consent remains in effect for a one (1) year period (as signed by the designee.) This form must be resigned at the year's expiration. This consent may be revoked at any time upon written request.

Signed_____ Date_____

Address_____ City/State_____

Phone_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Signed_____ Date_____

Patient Registration

Date: _____ **Email:**_____

Patient Name: _____ Relationship to Guarantor: _____

Date of Birth: _____Sex: M ___ F ___ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (___)_____ Referred By: _____

Next of Kin (not living at address listed above): _____ Relationship: _____

Address: _____

Siblings: Name Sex DOB SS#

_____

_____

_____

_____

_____

Father's Name: _____ Date of Birth: _____

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (___)_____ Work Telephone: (___)_____ Cell Phone: (___)_____

Employer: _____ Employer Address: _____

Social Security Number: _____ Marital Status: _____

Mother's Name: _____ Date of Birth: _____

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (___)_____ Work Telephone: (___)_____ Cell Phone: (___)_____

Employer: _____ Employer Address: _____

Social Security Number: _____ Marital Status: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ ID Number: _____ Group Number: _____

Full Name of Insured: _____ Policy Type: __HMO __PPO __PPC __Other: _____

If you belong to an HMO, do you also have other Group Insurance Coverage? _____ Yes _____ No

Co-Pay Amount: _____

How did you hear about us? _____

Previous Physician: _____

NOTIFY IN CASE OF EMERGENCY!!

Name: _____ Relationship: _____ Phone: (___)_____

Name: _____ Relationship: _____ Phone: (___)_____

Name: _____ Relationship: _____ Phone: (___)_____

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to **Ideal Pediatrics** to release any pertinent information to my insurance company upon request, and I also authorize payment directly to **Ideal Pediatrics**. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____ Witness: _____

MRN

Authorization for Release of Protected Health Information (PHI)

Patient Name | Date of Birth

Address | Telephone Number

I hereby authorize (Previous PCP or Hospital/Clinic) **to disclose the above-named individual's health information:**

Name (facility releasing information) **Address** **City** **State** **Zip**

Telephone Number

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

___Progress notes
___Consultations
___Most recent history and physical
___Immunization record
___Other_____
___Laboratory reports
___Radiology/Imaging reports
___Radiology films
___Two-way verbal exchange of communication
___ Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Ideal Pediatrics Medical Records | 1550 N Main St. Suite E | Columbia, IL | 62236

Name (facility receiving information) **Address** **City** **State** **Zip**

Telephone Number: 618-281-4325 **Fax**: 618-281-8393

Description of the purpose of the use and/or disclosure: (check one)

___Continuing Care
___Consultation
___Legal purposes
___Second Opinion
____Emergency/acute care
___Personal Use
___Social Security/Disability (provide copy of SSA Letter)
___Insurance
___Other: Please describe: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. The Clinic may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department of Illini Pediatrics, LLC. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____

Printed name of Patient or Patient's Representative

_____ **or** _____

Relationship to Patient **Legal Authority (attach supporting documentation)**

After hours/phone call policies

Phone calls: After business hours, Dr. Cangas, or a covering Pediatrician, will be available 24/7. All phone calls, during or after hours, are handled by a registered nurse as a first line of contact. Dr. Cangas is made aware of each and every phone call. Please note that, while you may see charges for phone calls on your billing statements, this fee should not be passed on to you. Many physician groups are beginning to bill for phone calls pertaining to patient care, since they take both physician and nurse time to answer. Some of these charges are being recognized and paid by insurance companies. However at this time we are not passing any additional cost to you the patient. If you receive a bill in error please call our office.

After Hours: Please call 888-424-4113. For after hours care, we recommend using Emergency Room staffed with a Pediatrician. (St. Anthony's, St. John's, St. Louis Children's, or Cardinal Glennon Children's).

Medication requests:

Antibiotics: Due to increases in antibiotic resistance seen globally, phone calls requesting them will generally not be honored. If you feel your child is ill enough to require antibiotics, please make an appointment so we can determine if he/she does need them and which one would be appropriate.

Other: As above, prescribing medication over the phone is not considered a safe practice. While this may have been acceptable in years past, today's medicine does not allow for such practices. This is for the protection and safety of your child.

Billing Policy

If you receive a bill that does not match your Explanation of Benefits (EOB) from your insurance carrier, please contact our billing company. If you are not happy with their explanation or the service they provide, please contact our office.

Balances are due upon receipt of your bill. If you cannot pay in full, please make monthly payments or contact us for options. Failure to make at least monthly payments will lead to collections. You will be responsible for collection agency fees, as well as your original balance, and any legal fees if litigation is necessary. Additionally, we will not be able to see your children if your account is in collections. If you have any questions or concerns about your bill, balance, or making payments, please contact our billing company

We suggest contacting your insurance company prior to a visit if you are unsure of how the plan is going to pay.

Fees

All fees cash or credit only. No checks.

Missed Appointments: $75.00/$100.00

Record copy/transfer: $10.00 (plus 25cents/page for printed)

Forms (FMLA or those not filled out at an appointment): $15.00

Services: It is your responsibility to determine if your insurance pays for services provided . Any charged incurred will be your responsibility.

01/01/2018

Ideal Pediatrics

This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information.
Please review it carefully.

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and Disclosure of Protected Information

- Federal law provides that we may use your PHI **for your treatment**, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to that specialist.
- Federal law provides that we may use your medical information **to obtain payment** for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the services rendered.
- Federal law provides that we may use your medical information **for health care operations** without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:
    1. required for public health purposes
    2. required by law to report child abuse
    3. required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
    4. required by law in judicial or administrative proceedings
    5. required for law enforcement purposes by a law enforcement official
    6. required by a coroner or medical examiner
    7. permitted by law to a funeral director
    8. permitted by law for organ donation purposes
    9. permitted by law to avert a serious threat to health or safety
    10. permitted by law and required by military authorities if you are a member of the armed forced of the U.S.
    11. required for national security, as authorized by law
    12. required by correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
    13. otherwise required or permitted by law.
    - Certain types of uses and disclosures of protected health information require authorization, these include:
        - uses and disclosures of psychotherapy notes
        - uses and disclosures of PHI for marketing purposes; and
        - disclosures that constitute the sale of PHI.
    - Other uses and disclosures not described in this Notice of Privacy Practices will be made only with an individual's authorization.

- ***Minors***

- For divorced or separated parents: each parent has equal access to health information about their unemancipated child(ren), unless there is a court order to the contrary that is known to us or unless it is a type of treatment or service where parental rights are restricted.
- We can release your medical information to a friend or family member that is involved in your medical care. For example, a babysitter or relative who is asked by a parent or guardian to take their child to the pediatrician's office may have access to this child's medical information. We prefer to have written authorization from the parent or guardian for someone else to accompany the child, and may make reasonable attempts to obtain this authorization.
- You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. A separate form is available for this purpose.
- Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights That You Have

- You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.
- You have the right to request confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location e.g. at home and not at work. Such requests must be made in writing to your physician. Our practice will accommodate reasonable requests.
- You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).
- You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosures we make of your medical information. This is a list of certain non-routine disclosures our practice has made of your health information for non-treatment, payment or health care operations purposes. An accounting does not have to be made for disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or disclosures made before April 14, 2003.
- You have the right to restrict certain disclosures of Protected Health Information to a health plan, for carrying out payment or health care operations, where you pay out of pocket in full for the healthcare item or service (only healthcare providers are required to include such a statement; other covered entities may retain the existing language indicating that a Covered Entity is NOT required to agree to a requested restriction.)
    - You are required to notify a Business Associate and a downstream Health Information Exchange of the restriction
    - A family member or other third party may make the payment on your behalf and the restriction will still be triggered
- You have a right to, or will receive, notifications of breaches of your unsecured patient health information.

- All requests must state a time period, which may not be longer than six (6) years from the date of disclosure.
- You have a right to receive a paper copy of our notice of privacy policies.
- You have a right to receive electronic copies of health information.

Obligations That We Have

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

Organization Contact Information

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

IDeal Pediatrics
1550 N Main St, Suite E
Columbia, IL 62236
618-281-4325
Contact Person: Jennifer Wiederhold

Patient Name:_____

No Show Policy

We understand that circumstance arise that do not allow you to keep your appointment, but please be courteous to us and our other patients by calling at least **24 hours** prior to your appointment time to cancel. You may also leave a voicemail or email to cancel your appointment. If missed appointments are avoided, this will allow as many children as possible to be seen. Other offices choose to overbook to make up for this, which can lead to long waiting times when all patients show up for their scheduled appointment. Due to this, we will limit overbooking our time slots, and will count on all parents to ensure their children are here for their appointments. Also, please note that arriving more that 15 minutes late will count as a 'no-show', and, in most cases, we will not be able to see your child. The decision to see your child at that point will depend upon the time and the schedule for the day**.**

FEES: **New patients appointments $100**. For established patients, a $75 charge will be assessed for each missed appointment, per child. This fee will be due prior to scheduling your next appointment. Missed same-day appointments will also discourage us from scheduling same day in the future. Understand that insurance will not cover this for you, regardless of your usual co-pay or deductible, therefore, you will be charged (This includes patients on public aid).

First missed appointment: $75 fee. (New patient appointments $100)

Second missed appointment: $75 fee .

Third missed appointment: $75 fee, and you will have a 30 day period to find a new physician. We will not perform non-illness care, such as physicals and forms during this time period and other appointments will be at our discretion.

While this may seem extreme to some, realize that this will help ensure that your child can be seen when needed. Most of you will not miss an appointment, so this will not be an issue. If you call and give us the at least the requested 24 hours notice, we can fill your spot with a sick child that may have been denied an appointment. Remember, it may be your child in need an appointment the next time. If you have any questions, please talk to any of the staff, including your doctor.

If you have extenuating circumstances that cause you to miss an appointment, please let us know.

I, _____, acknowledge that a copy of the No Show Policy (rev 04/23/18). I understand it is my responsibility to read the notices and ask questions as necessary.

Signature:_____ Relationship to patient:_____ Date:_____

Witness:_____ Date:_____

Revised 04/23/2018