West Sayville Pediatrics NPPC

1 Montauk Highway, West Sayville, NY 11796
Phone: 631-589-6727 Fax: 631-244-2866
Teresa Guthrie, RN PNP Jennifer Kalansky, DO FAAP Tara Verrier, DO FAAP

Dear Parents:

Please take a few moments to read and sign our Practice Policies.

1. **Co-pays:** These payments are required by your insurance company. To not collect co pays would be in violation of our contracts with the various managed care organizations. **Co pays are expected to be paid at the time of visit** by the accompanying parent or guardian. If an absent parent has financial responsibility, we must ask for payment from you and allow you to make arrangements with the responsible party. A fee of **$10.00** will be charged for co payments not paid at the time of the visit.
2. **Missed Appointments/Physical Exams:** Every household today has a hectic schedule and as a courtesy to other families we would appreciate your cooperation. An appointment for a physical exam is confirmed **two days** in advance by our staff. If you need to **reschedule** or **cancel** this type of appointment we ask that you give the office at **least 24 hours notice**. This will allow us to accommodate another patient in need of this type of service. A **$30.00** fee will be charged for **missing** this appointment. Any **no show** for a sick visit appointment will incur a **$25.00** fee as well.
3. **School/Camp Forms:** Forms required will be completed within 24 hours and a charge of **$5.00 per year,** per child will apply.
4. **Vaccinations: It is the policy of this practice to vaccinate according to the guidelines of the American Association of Pediatrics**. We understand if a parent would prefer to limit the amount of their child's recommended vaccinations per visit, however a service fee of $10.00 will be charged for each additional visit. Please note: **Any parent that refuses to vaccinate their child must seek the services of another physician. NO EXCEPTIONS!**
5. **Outstanding Balances:** In the tough economic times we are facing, we will work with any family to create an affordable payment plan should the need arise. **Finance charges** will accrue on balances over **30 days** and any unpaid balance over **60 days** will be charged an **administration fee of $30.00. Returned checks** will incur a check fee of **$30.00.** Contact our business office immediately with any questions on your balance Monday through Friday 9:00am-5:00pm
6. **Insurance: Please** bring your child's **current** insurance card with you to each visit. It is the responsibility of the parent or guardian to inform the practice of any changes in your insurance. **Failure to do so may result in a large balance. Parents** are responsible to know their **plan guidelines**. Please read through you plan for specifics such as the amount of well visits your policy allows, as well as coverage for vaccinations, yearly hearing and vision testing and lab work. Due to the increasing amount of choices within a plan and as employers try to cut costs on insurance, it is impossible for us to know your plan. Our business office is always here to help with any questions and will assist you in any way we can.

Thank you for choosing West Sayville Pediatrics we look forward to a long and pleasant relationship with your family.

____________________	____________________	____________________
Signature	**Printed Name**	**Date**

WEST SAYVILLE PEDIATRICS, N.P., P.C.
1 Montauk Highway • West Sayville, NY 11796
Phone: 631-589-6727 • Fax: (631) 244-2866

INSURANCE WAIVER

Please be advised that you are responsible to supply our practice with current insurance information as well as a current card.

If your plan requires you to choose a PCP (Primary Care Physician), it is your responsibility to do so before your child is seen in our office. In the event this is not done and the insurance company does not pay the claim, you will be responsible for payment in full for the visit.

I have read, understand and agree to the above requirements.

_______________________________ Signature of Parent/Guardian

_______________________________ Print Name of Parent/Guardian

Date of Signature: ____________________

WEST SAYVILLE PEDIATRICS N.P., P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to West Sayville Pediatrics N.P., P.C. (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

______________________________ ______________________________
Patient's Name Date

______________________________ ______________________________
Phone Number(s) (Cell/Home/Work) Email Address