



Patient Name _____

carolina developmental
pediatrics, pa

1001 W. Williams St.
suite 104
wpeh, nc 27502

p 919.362.5400
f 919.362.5400

www.cdped.com

CONSENT FOR TREATMENT

I grant permission to the attending physician(s) and professional staff or to their designees at Carolina Developmental Pediatrics, PA to render medical treatment or diagnostic procedures including psychological/neurodevelopment, physical and educational assessment as deemed necessary during my child's care. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made regarding the result of treatments or examinations.

I authorize Carolina Developmental Pediatrics, PA attending physician(s) and professional staff, or their designees to release medical information and billing information including, but not limited to information about my child's diagnosis, care and treatment for financial coverage to any third party or its agents requesting medical and other information for the purpose of determining eligibility for insurance or other public benefits, processing insurance claims or assessing quality, cost and appropriateness of medical care.

ASSIGNMENT OF BENEFITS

I hereby assign to Carolina Developmental Pediatrics, PA (CDP,PA) any insurance or other third-party benefits available for health care services provided to me. I understand that Carolina Developmental Pediatrics, PA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CDP, PA, I agree to forward to CDP,PA all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt

HIPPA COMPLIANCE

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. It is the policy of Carolina Developmental Pediatrics, PA to keep your information private except as stated above, and within the limits of the law. By signing this document I hereby state that I have had the opportunity to review the HIPPA documents and had any questions answered. I understand that this consent shall remain in force from this time forward and that I may revoke my consent at any time in writing.

Signature of Responsible Party

Printed Name of Responsible Party

Witness

Date



carolina developmental
pediatrics, pc

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Apex, NC 27502

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PATIENT FINANCIAL POLICY

In order for us to provide quality medical care we ask that you take the time to understand your responsibility as it relates to our policies regarding financial responsibility. If you have any questions regarding this, we will be glad to assist you.

INSURANCE

We are a participating subspecialty provider in the following plans:

- Blue Cross Blue Shield of North Carolina
- Aetna
- CIGNA
- Medicaid
- United Healthcare

It is your responsibility to know your insurance benefits. This is a contract between you and your insurance company and we can not say for sure which services will be covered. In the event that we do accept assignment of benefits from your insurance company please be aware that some of the services we may provide such as certain types of testing may be non-covered services under your plan. You will be 100% responsible for these charges. If you have any doubt, please ask prior to arranging the appointment. We expect you to:

1. Check that Dr. Moran is covered by your insurance carrier at the location on this letterhead.
2. Be aware of your specific covered benefits prior to receiving services.
3. Check that all pre-approval requirements are met to avoid denials.

We must have accurate billing information at each visit in order to process claims according to your insurance plan's guidelines. If you fail to provide accurate information to process your claim, you will be held responsible.

PAYMENT

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE. This includes: all co-pays and deductibles. In the event that your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for all charges incurred. We accept: Cash, Checks and Credit Cards (MasterCard and Visa). In the event of overpayment on your account, overpayments of greater than \$20.00 will be sent to you. Overpayments of \$ 20.00 or less will be held in your account and will be credited to your next visit.

UNPAID BALANCES

Payments not received in 60 days may be transitioned to patient responsibility and you may be required to make other payment arrangements. Any balance not paid after 90 days will be turned over to a collection agency. We shall be entitled to reasonable attorney fees and court cost should litigation ensue in order to collect for unpaid bills.

MISSED APPOINTMENTS

Since we typically schedule considerable time for initial and follow-up visits, our policy is to charge \$75.00 for missed appointments unless canceled at least 24 hours in advance. There may be an additional fee for extended testing sessions. We can not file this with your insurance plans as they will not pay for this. Please help us by keeping, or canceling in advance, any appointments you schedule.

PHONE APPOINTMENTS

Our practice provides certain types of telephone care free of charge to answer routine questions regarding medication dosage, side effects, follow-up on lab results or referrals or general questions that can be answered through our regular support staff. However, on occasion there is a need for further care through telephone calls or e-mail communication which is more complicated and involves physician time expertise and documentation of the care delivered. These types of communications are now recognized by American Medical Association and American Academy of Pediatrics as billable medical encounters and will be charged according to the following schedule: Up to 10 min, (CPT 99441) \$25.00; 11-20 min (CPT 99442) \$50.00; 21-30 min (CPT 99443) \$70.00. We will attempt to bill your insurance carrier for these services but ask for payment up-front. Please let us know if you have any questions.

Thank you for taking the time to read and understand this Financial Policy. Please let us know if you have any questions.

I have read and agree to this Financial Policy:

Signature of Responsible Party

Printed name of Responsible Party

Witness

Date