DuPage Pediatrics, Ltd 1306 Plainfield Road Darien, IL 60561
P-630-810-0900 F-630-810-0937 www.dupagepediatrics.com

Office Policies, Financial Policies & Consent to Treat

YOUR INFORMATION: Please provide your most current contact information including phone/cell numbers, address, email address, and driver's license/photo identification, etc. at the time of registration or as requested by the practice at any time. Also, please bring your insurance card to each visit to ensure accurate filing and payment from your insurance carrier.

CELL PHONE USAGE: Please refrain from using your cell phone when your child is in the room being seen for their appointment and also when checking in and/or out of the office.

WALK-IN-POLICY/APPOINTMENTS: Patients with pre-scheduled appointments are seen both during the week and on Saturdays. If you have an appointment scheduled for a child, and would like an additional child to be seen, please call our office in advance of coming to the office. We will do our best to accommodate you. Please provide a 24-hour notice if an appointment needs to be cancelled as a courtesy to other patients seeking our services. Without the 24 hour notice, a $25.00 cancellation fee will be applied. Excessive no call/no shows may result in termination of care by our physicians.

TREATING MINORS WITHOUT A PARENT OR LEGAL GUARDIAN: DuPage Pediatrics, Ltd. requires a dated, signed Authorization for Medical Treatment of a Minor form when a minor attending their appointment by themselves or is being accompanied by a person other than the birth parent or legal guardian. This includes step parents, grandparents, day care providers, nanny, babysitter, etc. Non-emergency care may be denied without this form. This form is available on the DuPage Pediatrics website: www.dupagepediatrics.com

INSURANCE CO-PAYMENTS, DEDUCTIBLE, AND CO-INSURANCE: If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. Insurance companies do not pay all fees and may exclude certain services from coverage. Please pay co-payments and any outstanding balances at the time of your visit. It is your responsibility to understand your insurance plan. **Please contact your insurance company to verify the benefits available including well baby care and vaccinations.** Some insurance companies require pre-authorization to reimburse for MRI or CT scans. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. It is the responsibility of the guarantor to pay any outstanding charges not covered by their insurance carrier even if the insurance company is billed as a courtesy.

If during your child's well visit, there is a new medical problem or a pre-existing medical condition that must be addressed, the physician may need to provide an additional office visit service (called a sick visit) to provide proper care for your child. This is a different service, and it is billed to your health plan in addition to the bill for preventative services provided on the same day. If you have a co-payment for office visits, coinsurance, or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.

USUAL AND CUSTOMARY: Some insurance plans may indicate that our fees are above "usual and customary." If we participate with your insurance plan, your insurance plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. Unless we have specifically contracted with your carrier directly or through a participating network, it is expected that you will be liable for all fees.

SLOW INSURANCE RESP0NSE: You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.

STATEMENT POLICY: Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees.

COLLECTION AGENCY: Accounts with a patient due balance over 90 days old are subject to transfer to an outside collection agency.

FINANCIAL RESPONSIBILITY/PAYMENT METHODS: By signing below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability and will need to collect from any other responsible party on their own. We accept cash, check, and major credit cards. Our Business Office can arrange a payment plan if needed.

PRESCRIPTION REFILL/FORM COMPLETION/REFERRAL REQUEST: Please allow 24-48 hours for all forms to be completed, insurance referrals and prescription refill request to be processed. Please note that in compliance with Illinois State Law, some medication prescriptions must be picked up at our office or mailed to the home address. These prescriptions will not be sent directly to your pharmacy and you will be notified in advance if this is the case. Please be prepared to show identification if requested when picking up these items. Items will be released to a minor only with written authorization and identification.

EMERGENCIES: Our office will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you will call 911, receive paramedic intervention, and seek the nearest emergency room.

MEDICAL RECORDS: The medical chart is the property of the practice. However, copies or summaries of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to those published annually by the State of Illinois Comptroller's Office. This fee schedule is available upon request.

TELEPHONE ENCOUNTERS: With regard to telephone calls requesting to speak to the doctor; a charge may be incurred if certain criteria are met such as the length of the call. Most insurance companies do not cover the costs of these encounters. Payment for these services is your responsibility.

PATIENT DISCHARGE: The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

CONSENT TO TREAT: I, the undersigned patient, parent or legal guardian is responsible for consenting on patient's behalf, hereby request and consent to the children listed below, to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the patient's care. I hereby authorize the clinicians of DuPage Pediatrics, Ltd., **to provide vaccinations according to the AAP guidelines** to the children listed below.

I have read all the terms of this policy and by my signature below, I attest that I fully understand each item and agree to the terms above.

Signature of Parent, Legal Guardian or Patient (if 18 years old or older):____

Printed name of person signing and relationship to patient(s):____

Child/Children(s) Name(s): ____

Date____

2/6/2019