DuPage Pediatrics, Ltd 1306 Plainfield Rd. 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 such as phone/cell numbers, address etc. 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. 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 is being accompanied to their appointment by themselves or by a person other than the birth parent or legal guardian. This includes step parents, grandparents, day care providers, nanny, baby-sitter, etc. Non-emergency care may be denied without this form. This form is available on the DuPage Pediatrics website: www.dupagepediatrics.com

PAYMENT/RESPONSIBLE PARTY: Please pay the co-pay your insurance requires and any outstanding balance at the time of your visit. **Please contact your insurance company to verify the benefits available including well baby care and vaccinations.** It is the responsibility of the guarantor to pay any outstanding charges not covered by their insurance carrier. Some insurance companies require pre- authorization to reimburse for MRI or CT scans. The business office can arrange a payment plan if needed. In cases where there is a divorce, the parent bringing the child into the office will be responsible for payment and will need to collect from any other responsible party on their own. With regard to phone calls requesting to speak to the doctor; a charge may be incurred if certain criteria are met such as the length of the call.

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.

PRESCRIPTION REFILL/FORM COMPLETED/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.

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.

PLEASE SIGN BELOW TO VERIFY THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE POLICY AND CONSENT TO TREAT.

Signature of Patient, Parent or Legal Guardian:_____

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

Child/Children(s) Names (s): _____

Date_____ 03/17/2017