Crestwood Pediatric ASSOCIATES, PC

10623 Crestwood Drive Manassas, VA 20109 PH: 703-361-7131 FAX: 703-330-2065

14535 John Marshall Hwy., Gainesville, VA 20155 PH: 703-753-6184 FAX: 703-753-2988

ACCT#:_____

OFFICE & INSURANCE POLICIES AND CONSENT AGREEMENT

We are a same day sick scheduling office. Our phones turn on at 8:15 AM. If you call for a sick appointment in the morning, we normally can see your child that day. **After hours evening Sick appointments are only scheduled after 3:00 PM.** Well appointments need to be made well in advance, particularly if you require an After hours evening or After hours Saturday time. Please call our office 24 hours in advance if you will not be keeping an appointment, so that time slot can be used for another child. **We have a $50 Missed Appointment /Same Day Cancelled fee.** In order to keep other children's wait times to a minimum, patients arriving more than 15 minutes late may be required to reschedule.

As a courtesy, we participate with many insurance plans and accept their schedule of benefits. **However, we do require payment at the time of service if we cannot verify your child's insurance**. If your policy requires you to choose a physician, one of our doctors must be the primary care physician at the time of the appointment. New insurance information must be presented at the time you sign-in for your child's visit. We allow 30 days from birth for newborn coverage to take effect; after that time, you become responsible for payment.

Since medical insurance is a contract between the patient and the insurance company, we expect insured patients to be familiar with their policy, its benefits, limitations and referral requirements. If insurance payment is not received within 45 days of submission of the claim, the balance becomes your responsibility. It is your responsibility to make sure your insurance company pays on time. Non-emergency referrals require 48 hours to complete. Referral forms (if required by your policy) must be picked up prior to your appointment with the specialist. They will not be faxed, or mailed.

I understand that, in most cases, my insurance is designed to reduce my cost not eliminate it. I also understand that there may be charges for services not covered by my insurance that I am responsible for. For example, you will always be responsible for your co-pay, co-insurance and deductible regardless of which billed office service they assign it to. Payment of co-pays, co-insurance, waived tests, and deductibles is due at the time of service. Payment of balances is due upon receipt of my statement. I am financially responsible for all charges not covered by this assignment and all charges if complete or accurate insurance information is not provided by me. If I have questions about a denial or amount paid, initial questions should be directed to my insurance company. Please notify our billing department if a claim is going to be reprocessed.

I also understand that in the event this account is referred for collection action, I agree to reimburse Crestwood Pediatric the fees of any collection agency, which may be based on a percentage at the maximum of 28% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

_____ _____

Initial of Parent/Guardian **Date**

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OFFICE & INSURANCE POLICIES AND CONSENT AGREEMENT *CONT'D*

ACCT#:_____

Vaccination Policy

(Please read and understand thoroughly)

We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Centers for Disease Control and endorsed by the American Academy of Pediatrics. We believe in their safety and effectiveness and do not believe they are in any way related to autism. It is our desire to protect our community and the children in our waiting room from vaccine preventable diseases. We do not support delaying or spacing out of vaccinations. This puts our children at unnecessary risk and is not supported by any of the evidence based peer reviewed medical studies. Therefore, we would like to inform the parents and guardians of our patients that if you plan to delay or decline routine childhood vaccinations due to religious or other philosophical reasons, we will ask you to choose another healthcare provider that shares your views.

I understand that under state law (Virginia Code Section 32.1-45.1), health care providers are authorized to test patients for HIV antibodies or Hepatitis B and C whenever the health care provider or any person employed or under the direction or control of a health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus or HIV (which causes Aids), or Hepatitis B or C virus. According to this law, I understand that I will be deemed to have consented to such testing of my child, and to have consented to the release of the test results to the health care provider or other person who may have been exposed. Positive test results will also be disclosed to me as medically necessary, as otherwise required for me to seek treatment, and as required or permitted by law.

I understand that records including immunizations of a minor child will be maintained until the child reaches the age of 18, with a minimum time for record retention of six years from the last patient encounter regardless of age. The exception to this policy will be when the records are transferred to another physician, or provided to the patient, (parent/guardian).

I certify that I have read both pages of this form or had it read to me before I signed this agreement, and that I understand its content and significance. I further certify that I was provided an opportunity to ask questions regarding the content of this form, and those questions, if any, have been answered to my satisfaction.

_____ _____ _____

Signature of Parent/Legal Guardian **Witness Signature** **Date**