North Shore Pediatrics

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Patient Consent, Authorization and Agreement

Welcome to our practice! This document contains the information required by Law and many Health Plans to protect your child's rights, and inform you of his/her rights and your responsibilities. We apologize that it is of such length, but we must comply with the terms and conditions that are imposed upon us so that we may better serve our patients. By signing this form you are granting consent, authorizing and agreeing to the following terms and conditions:

Consent to Treat: I, as the legal guardian and legal representative of the minor named below, authorize and request NORTH SHORE PEDIATRICS to provide medical care to the child or minor reasonable by today's standards at NORTH SHORE PEDIATRICS.

Our Notice of Privacy Practices (HIPAA): I acknowledge receipt of Privacy Practices which provides more detailed information about how NORTH SHORE PEDIATRICS and its agents may use and disclose protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this clause and we encourage you to read it in full. You may obtain a current and revised copy of notice by request. You do not need to acknowledge receipt of our notice in order to receive care.
Initials: ___________ Date: _____________

Notice of Deemed Consent to HIV, HEP B, and HEP C Blood Testing: A Virginia law was enacted in 1989 that allows health care providers to test their patients for HIV antibodies, Hepatitis B, and Hepatitis C when a health care worker is exposed to the blood or body fluids of a patient which may transmit human immunodeficiency virus (HIV), the virus which causes aids or Hepatitis B. Because this is a law, in the event of such exposure, you will be deemed to have consented to such testing, and to have consented to the release of test results to the exposed worker. Except in emergencies, you will be informed before any of your blood is tested for HIV antibodies, Hepatitis B and Hepatitis C, the testing will be explained to you and you will be given the opportunity to ask any questions you may have. You will be provided with the test results and appropriate counseling. Test results, if positive, are required by law to be reported to the Virginia Department of Health. I have read and understood the above information.
Initials: ___________ Date: _____________

Assignment of Benefits: I hereby assign to NORTH SHORE PEDIATRICS any insurance or other third party benefits available for health care services provided to the minor. I understand that NORTH SHORE PEDIATRICS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to NORTH SHORE PEDIATRICS, I agree to forward to NORTH SHORE PEDIATRICS all health insurance and other third party payments that I receive for services rendered to the child immediately upon receipt. I further state that the insurance information provided is accurate and the Health Plan does cover the child on the date of service, and acknowledge that I've been extended credit based on the written information provided. I also understand that making a false statement in order to be granted credit for services provided constitutes a crime against The Commonwealth of Virginia.

Managed Care: If you are enrolled in a managed care insurance plan (i.e., HMO) you must receive a referral from out office *BEFORE* seeing a specialist. NO retroactive referrals will be given.

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Insurance Coverage Waiver: I understand that my child or minor's eligibility for coverage by his/her insurance company cannot be confirmed at this time. I wish for him/her to receive medical service from NORTH SHORE PEDIATRICS. If it is determined that we are not eligible for coverage, the health plan denies payment, or the services performed are not covered by your health plan or it applies to your deductible; I understand that I will be solely responsible for payment of all services provided today plus a $25 collections fee.
Initials: ___________ Date: _____________

Advanced Beneficiary Notice (ABN): Sometimes insurance companies or health plans do not pay for all of your health care costs. Insurance companies or health plans only pay for "medically necessary" or "covered" items or services when their specific health plan rules are met. The fact that your insurance company or health plan provider may not pay for a particular item or service does not mean that your minor does not need it or should not receive it. You are responsible for knowing and will advise the agent(s) of NORTH SHORE PEDIATRICS of items not covered by insurance policy covering the care of the minor. I want the child/minor to receive these items or services. I agree to be personally and fully responsible for payment of all such services.
Initials: ___________ Date: _____________

Missed Appointments/Late Cancellations: Broken appointments represent a cost to us, to you, and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge a $25 fee for any missed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Payment for Services: I agree to be solely responsible for all performance and payments of all charges incurred today because of my request for medical services including but not limited to co-pays, deductibles, and other terms specifically listed above. Payment is due at time of service. I understand that all unsettled account will be turned over to collections after 120 days. I have read and understand NORTH SHORE PEDIATRICS financial policy. I agree to assign insurance benefits to NORTH SHORE PEDIATRICS whenever necessary.
Initials: ___________ Date: _____________

Person(s) allowed to bring patient to office visit other than parents/guardian:

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I certify that I have received a copy of this authorization, consent, and agreement. I further warrant that I am the legal and personal representative of the minor named below.

Name of Minor or Child Patient: ____D.O.B.___/___/___

SIGNATURE: ____ DATE: ___/___/___

PRINT NAME: ____

RELATIONSHIP TO PATIENT: ____