ABC PEDIATRICS, LTD

☐Gus Rousonelos, MD	☐Erin Shanks, MD	☐Karolyn Law, MD	☐Ushma Patel, MD	☐Pamela Persak, MD

PATIENT INFORMATION

Last Name	First Name	Middle Name	Date of Birth	Sex
				☐Male ☐Female
				☐Male ☐Female
				☐Male ☐Female
				☐Male ☐Female
				☐Male ☐Female

PATIENT ADDRESS

Address:

City, State, Zip:

Mail Statements to this address? ☐Yes ☐No

PRIMARY PHONE:

PRIMARY EMAIL:

PARENT INFORMATION

MOTHER/GUARDIAN 1		**FATHER/GUARDIAN 2**	
Last Name:		Last Name:	
First Name:	DOB:	First Name:	DOB:
IF DIFFERENT THAN ABOVE		**IF DIFFERENT THAN ABOVE**	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Mail Statements to this address? ☐Yes ☐No		Mail Statements to this address? ☐Yes ☐No	
Cell Phone:		Cell Phone:	
Email Address:		Email Address:	
Employer:		Employer:	
Work Phone:		Work Phone:	
Are you the primary insurance carrier? ☐Yes ☐No		Are you the primary insurance carrier? ☐Yes ☐No	

PREFERRED CONTACT METHOD

☐Primary Phone ☐Primary Email ☐Cell Phone ☐Work Phone

PREFERRED PHARMACY

Name:	Phone:
Address:	City, State, Zip:

LOCAL CONTACT *(OTHER THAN PARENT)*

Last Name:	First Name:
Home Phone:	Cell Phone:
Email:	Relationship to patient:

AUTHORIZATION AND ACKNOWLEDGEMENT

I authorize you to give my child/children reasonable and proper medical care by today's standards. I hereby authorize the physician to release information related to any claim. I recognize and accept full responsibility for all professional services rendered and further authorize the insurance company to pay benefits directly to the physician.

Signature of Parent: ______________________________ **Date:** ______________

How were your referred to our practice? ______________________________

Financial Policy of ABC Pediatrics, Ltd.

Our professional staff is committed to providing you with quality pediatric care and our business office is committed to assisting you with the financial obligations of your medical care.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Therefore, we have outlined our financial policy so that patients will better understand the billing process and their responsibility in it.

ABC Pediatrics, Ltd. will:

1. File primary insurance claims on your behalf in a timely manner.
2. Seek information to process claims and answer any questions about claims.
3. Issue statements to you once insurance has made payment for services.
4. Accept payment by cash, check, and most major credit cards.
5. Arrange payment plans when necessary through the office manager.
6. Help resolve billing problems diligently for 60 days.

Your responsibilities will be to:

1. Complete our patient information form and supply any insurance information that is necessary to process your claims including benefits information.
2. Notify us of any changes in your insurance status or insurance company.
3. Pay your co-pay at the time of service. If you cannot pay your co-pay at the time of service a $20.00 fee may be charged to you.
4. Pay any outstanding balance which is unpaid, denied or delayed by your insurance carrier beyond 60 days after the date of service.
5. Call your insurance carrier, at our request, to expedite payment for delayed claims before our 60 day limit has been reached.
6. Call your insurance carrier when a submitted claim was denied. Denied and disputed claims do not suspend your requirement to pay for services rendered.
7. Be responsible for deductibles or uncovered expenses. This may include charges for screening forms that are required by law or recommended by the American Academy of Pediatrics. Patients seen for a well visit may incur additional charges for any significant services, such as counseling for immunizations, risk factor reduction intervention, or any illness, condition or procedure. Patients seen in the office during regularly scheduled evening, weekend or holiday office hours will incur an additional charge.
8. Forward any payment which received by you from the insurance company that is owed to ABC Pediatrics, Ltd.
9. Pay a $25.00 fee per check returned to us by the bank for non-sufficient funds (NSF).
10. File claims with your secondary insurance carrier. Any balance due after primary insurance has processed is due immediately. NOTE: We do not file Medicaid as secondary insurance.
11. Authorize ABC Pediatrics, Ltd. to provide your insurance carrier with any clinical or financial information that they may require.
12. Pay in full for office visit at the time of service if no current insurance card is presented.
13. Inform us of any appointments you need to reschedule or cancel. You may be charged a $50.00 fee for sick appointments not cancelled within an hour and well visits within 24 hours. You will be charged $50.00 for a "no show appointment.
14. We will do our best to resolve insurance issues and will enlist your help when necessary before asking that you pay any balance that is 60 days past due. Your insurance is a contract between you and your insurance carrier. Therefore you will be more likely to get the carrier to meet their financial obligation when they delay payment on your claims. Please remember that we file insurance as a courtesy to you. You, not the insurance carrier, are ultimately responsible for any unpaid fees.

I certify I have read, understand and agree to adhere to ABC Pediatrics, Ltd. Financial Policy.

________________________________ ____________ __________________________

Responsible party's signature   Date   Patient's name printed

Patient Name ____

____

____

For Office use:
Acct# ___________
Date ____________
Initials __________

The following information is needed to provide service and process claims with your insurance provider. Please contact your insurance carrier using the toll free number on the back of your insurance card and ask the following questions.

Our provider tax ID# is 36-4122365. Give the insurance company our tax ID # and ask if we are in their network.

1. Name of insurance company? ____
2. What type of plan is this? PPO, POS, EPO or other
3. Name of network? __________________________________
4. Effective date of policy ______________________________

If In-Network ask:

Deductible amount
Individual $________
Family $________
Date deductible starts over ________
What services are subject to ded? (Circle)
Hospital, office visits, immunizations, labs,
Wart treatments, strep tests

Lab preferred provider? ________________
Medical/sick visit copay $__________
Well baby/child care copay $________
Are immunizations covered? Yes / No
At what percentage? ___________%
Any limits on immunization? Yes / No
If yes, dollar amt limit is $_______per ___
Are there any limits on well care? Yes / No
If yes, dollar amt. limit is $____ per ____
Number of visits limit is _____ per _____
Age limit? _____________

If Out-Of-Network ask:

Deductible Amount
Individual $_______
Family $_______
Date deductible starts over _________
What services are subject to ded? (Circle)
Hospital, office visits, immunizations, labs,
Wart treatments, strep tests

Lab preferred provider? _______________
Medical/sick visit copay $______________
Well baby/child care copay $___________
Are immunizations covered? Yes / No
At what percentage? ________%
Any limits on immunizations? Yes / No
If yes, dollar amt limit is $____ per ____
Are there any limits on well care? Yes / No
If yes, dollar amt limit is $_____ per ____
Number of visits limit is ______per _____
Age limit? ____________________

Please call our office with this information as soon as possible and return this completed form to our office at your first visit.

We hope this provides you with a basic understanding of our financial policy. Our staff is trained to help you with any insurance questions you may have. Only your employer can address how your plan is administered. If you have any questions regarding our payment structure, please feel free to contact our business office.

ABC PEDIATRICS, LTD
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called "protected health information" or "PHI." We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

<u>Treatment</u>: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

<u>Payment</u>: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

<u>Health Care Operations</u>: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

<u>Legal Requirements</u>: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

<u>Public Health</u>: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

<u>Health Oversight Activities</u>: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public

benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: We do not engage in fundraising activities. We do not engage in marketing activities, and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure

without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (630)355-0003. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations), You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website at www.abcpediatrics.net or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

EFFECTIVE DATE: ______________________

Date: ________________________ **Relationship to patient:** ________________

Staff signature: _________________ **Date:** _______________________

ABC Pediatrics, Ltd.

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Erin L. Shanks, MD
Karolyn D. Law, MD
Ushma Patel, MD
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Suite 300
Naperville, IL 60540
Phone (630) 355-0003
Fax (630) 355-9822

CONSENT FOR RELEASE and USE of CONFIDENTIAL INFORMATION and RECEIPT of NOTICE of PRIVACY PRACTICES

I, _______________________, hereby give my consent to ABC Pediatrics, Ltd., to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record (s) of ________________________________.

________________________________ ____

________________________________ ____

________________________________ ____

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available on our website.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: ____ Date:________________

If you are not the patient, please specify the relationship to the patient_________________________________.

ABC Pediatrics, Ltd.
Infant Pediatric Health History Form—Initial Visit

Child's Name ______________________Age _____
Your Name _________________________________

Child's DOB _____________ Today's date ________
Relationship to Child _________________________

Pregnancy and Birth

Maternal Exposures:

Medication? ☐ No ☐ Yes _______________
Drugs/Alcohol? ☐ No ☐ Yes _______________
Tobacco? ☐ No ☐ Yes _______________
Infection/Grp B strep? ☐ No ☐ Yes _______________

Birth problems for patient:

Jaundice? ☐ No ☐ Yes _______________
Infection? ☐ No ☐ Yes _______________
Breathing? ☐ No ☐ Yes _______________
Low Blood Sugar? ☐ No ☐ Yes _______________
Oxygen Use? ☐ No ☐ Yes _______________
NICU stay? ☐ No ☐ Yes _______________

Was your child premature? ☐ No ☐ Yes, born at ____weeks
Delivery: ☐vaginal ☐c-section ☐breech ☐forceps
Where was your child born? _________________________
Is the child yours by ☐birth ☐adoption ☐ stepchild ☐other
Birth weight ________________ Length ______________
Mother's blood type? _________________________________
Other problems in the newborn period __________________
____

Past Medical History of Your Infant

Any medications taken regularly? ☐ No ☐ Yes
Which ones? _____________________________________
Any allergic reactions to medications? ☐ No ☐ Yes
Which ones? ______________________________________
Any reactions to immunizations? ☐ No ☐ Yes
Which ones? ______________________________________
Any hospitalizations other than for birth? ☐ No ☐ Yes
For what? ____
Other history? ☐ No ☐ Yes
Which kind? ______________________________________

Safety / Environment

Is your water heater set to 120 degrees? ☐ Yes ☐ No
Is there a working smoke alarm on each floor in the house? ☐ Yes ☐ No
Does your child always use a car seat in the back seat when riding in the car? ☐ Yes ☐ No
Do you place your baby to sleep on his/her stomach? ☐ No ☐ Yes
Do you have help or support easily available? ☐ Yes ☐ No
Any stresses in the family? ☐ No ☐ Yes
Describe ____
____
____
Where does the baby sleep: _____parents' room, ____nursery
______sibling's room, ______other?

Feeding and Nutrition

Any unusual feeding problems? ☐ No ☐ Yes
Breast or formula fed? _______________________________
If on formula, which one? ____________________________
Does he/she take vitamins? ___________________________
If breastfeeding, how long do you plan to continue? ________

Review of systems

Any eye problems? ☐ No ☐ Yes
Difficult or noisy breathing? ☐ No ☐ Yes
Heart murmur or heart problem? ☐ No ☐ Yes
Problem with stools (diarrhea/constipation)? ☐ No ☐ Yes
Is he/she irritable or colicky? ☐ No ☐ Yes
Any skin conditions? ☐ No ☐ Yes
Problem with vomiting or excessive spit up? ☐ No ☐ Yes
Please list any other medical problems or explain above problems. ____
____

Social History

Who lives in the child's household? ☐Mom ☐Dad ☐Step ___
☐ Siblings (# ___) ☐Grandparents ☐Other ________
Child's parents are ☐married ☐unmarried ☐ divorced ☐other
Mom's Occupation __________Dad's Occupation_________
Childcare ☐parents ☐relatives ☐daycare ☐babysitter/nanny
Days per week in childcare (not with parent) ______
Any pets? ☐ Yes ☐ No ____________________________
Do any household members smoke? ☐ Yes ☐ No
Is there a gun in the home? ☐ Yes ☐ No
Is it locked and separate from ammunition? ☐ Yes ☐ No

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Brother	Sister	Paternal Grandfather	PaternalGrandmother	Maternal Grandfather	Maternal Grandmothe
Asthma								
Allergies								
Anemia								
Blood Disorder								
Cancer								
High Cholesterol								
High blood pressure								
Heart attack/disease								
Diabetes								
Thyroid disease								
Seizures								
Migraines								
Autism								
Depression/anxiety								
Alcoholism								
ADD/ADHD								
Other issues								

Please explain all positives.___________________________
____

ABC Pediatrics, Ltd.
Pediatric Health History Form—Initial Visit

Child's Name ________________________________
Your Name __________________________________

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? ________________________
Is the child yours by ☐birth ☐adoption ☐ stepchild ☐other
Delivery: ☐vaginal ☐C-section
Was your child premature? ☐ No ☐ Yes, born at ____weeks
Birth weight ________________ Length ______________
Other problems in the newborn period _________________
____

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with: (explain)

☐ Asthma or reactive airway disease ____________
☐ Wheezing or bronchiolitis _________________
☐ Seasonal allergies _________________________
☐ Eczema _____________________________________
☐ Food allergy ______________________________
☐ Recurrent ear infections ___________________
☐Pneumonia _________________________________
☐Urinary tract infections ____________________
☐Seizures ____________________________________
☐Anemia _______________________________________
☐Broken bone /concussion ____________________
☐Depression/anxiety ________________________
☐Heart murmur ______________________________
☐Constipation ______________________________
☐Chicken pox ______________________________
☐Attention Deficit Disorder __________________

Other chronic medical conditions ______________________
____
Has your child ever been hospitalized? ☐No ☐Yes (explain)
____
Previous surgeries and dates __________________________
____
Please list any specialist your child has seen, dates and reason:
____
____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
____
____
Current medications and dose: ________________________
____
____

Development/Nutrition

Did/does your child have delayed development? ☐No ☐Yes
How does this child compare to others his or her age? _____
____
What grade is he/she in? ___________________________
Has she/he had any trouble in school? ☐No ☐Yes
Does he/she get along with other children? ☐No ☐Yes
Do any foods disagree with him/her? ☐No ☐Yes
Which ones? _____________________________________
Does he/she get fluoride? ☐No ☐Yes
How many hours per day does your child spend:
Watching TV _____ Computer _____ Video games _____
Hobbies/extracurricular activities __________________

Date of Birth ___________________ Age ______
Relationship to Child ______ Today's date________

Social History

Who lives in the child's household? ☐Mom ☐Dad ☐Step ___
☐ Siblings (# ___) ☐Grandparents ☐Other ________
Child's parents are ☐married ☐unmarried ☐ divorced ☐other
Mom's Occupation __________Dad's Occupation_________
Childcare ☐parents ☐relatives ☐daycare ☐babysitter/nanny
Days per week in childcare (not with parent) ______
Any pets? ☐ Yes ☐ No ______________________________
Do any household members smoke? ☐ Yes ☐ No
Is there a gun in the home? ☐ Yes ☐ No
Is it locked and separate from ammunition? ☐ Yes ☐ No

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Brother	Sister	Paternal Grandfather	PaternalGrandmother	Maternal Grandfather	Maternal Grandmother
Asthma								
Allergies								
Anemia								
Blood Disorder								
Cancer								
High Cholesterol								
High blood pressure								
Heart attack/disease								
Diabetes								
Thyroid disease								
Seizures								
Migraines								
Autism								
Depression/anxiety								
Alcoholism								
ADD/ADHD								
Other issues								

Please explain all positives: __________________________
____
____
____

Review of systems

Please review the topics listed below. Check if you have a concern about your child:

☐ Physical problem
☐ Development
☐ Sleep patterns
☐ Snoring
☐ Diet/nutrition/weight
☐ Amount of physical activity
☐ Emotional development
☐ Relationships with parents
☐ Self-image or self-worth
☐ Depression
☐ Anxiety/stress
☐ Attention/impulsivity
☐ Acting out/behavior issues
☐ School grades/absences
☐ Other ____________________________

Electronic Communication User Agreement

And Informed Consent

Completion of this form is necessary prior to engaging in electronic communications with ABC Pediatrics, Ltd. At current time, ABC Pediatrics, Ltd. does not have a patient portal through which ABC Pediatrics, Ltd. and patients may securely communicate.

Electronic communication policy

"Electronic communication" means unsecured e-mail or text messaging with patients outside of a patient portal.

The following policies and limitations apply to the use of ABC Pediatrics' electronic communication:

1. Electronic communications is not for emergency purposes. If you are having an emergency, dial 911 or go to your local hospital.
2. Correspondence via electronic communication is supplemental to physician/patient encounters. ABC Pediatrics, Ltd. will not provide electronic communication-based diagnosis and treatment.
3. Sensitive subject matter, such as HIV/AIDS, STDs, mental health, behavioral health, drug treatment, or genetic testing information, cannot be discussed through electronic communication.
4. Communications sent via electronic communication must be courteous, respectful, appropriate, fact-based and truthful.

Conditions of participation

Electronic communication with ABC Pediatrics, Ltd. is restricted to the patient (s). This type of communication is optional, and we reserve the right to suspend or terminate it at any time. If the practice suspends access, you will still have access to copies of your medical record and other health information upon request.

The patient acknowledges that he/she agrees to comply with the ABC Pediatrics' Electronic Communication Policy outlined above.

The patient also acknowledges and understands that any information conveyed using unsecured electronic communication is not protected and may be viewable in the public domain.

Patient Name(s) ______________________ ______________________________

Parent Signature ____

Date ____

E-mail address ____

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CANCELLATION POLICY/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call or cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

If a sick appointment is not cancelled at least one hour in advance or a well visit at least 24 hours in advance, you will be charged a fifty ($50) fee; this will not be submitted to or covered by your insurance company.

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW and charged a fifty ($50) fee. This will not be submitted or covered by your insurance company.

Scheduled Appointments

We understand that delays can happen; however, we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time, we may have to reschedule the appointment.

____
Print name (s) of Patient (s)

____ ______________
Signature of Parent or Guardian **Date**