Iberia Pediatrics OFFICE POLICIES

We consider it an honor and a privilege to care for your children. We work hard to keep quality, respect, and positive communication alive and well at our office. Your visit is made more productive by reducing waiting time to a minimum, and that is only possible when everyone on our team takes every step to help you get in and out as quickly as possible. Please help us in providing quality, efficient care by taking note of the following:

1. Please arrive 10-15 minutes before your appointment time. Coming late or arriving very early disrupts the natural flow of patients and can increase your waiting time.
2. Walk-ins may not always be able to see a doctor or, at least, may have to wait longer than those with scheduled appointments.
3. Do not miss appointments unless you have a strong reason. Call to reschedule as soon as you realize that you cannot keep your appointments, preferably 24 hours in advance. Missed appointments will incur a **$30.00 fee** per child per missed appointment. Families who miss multiple appointments may be discharged.
   As a courtesy, we will make every effort to remind you of scheduled appointments.
4. Please do not ignore your financial obligations including co-pays, unpaid balances, and non-covered services. This is a private practice that is NOT subsidized by the government.
5. Bring all recently prescribed medications, and be ready to answer any questions about your child's recent illness or visits to other providers.
6. Please allow up 24 hours for medication refills to be ordered.
7. Try to use only one pharmacy when possible.
8. Paperwork and forms, including vaccine records, may take up to 3 business days to be completed. Work or school excuses will be provided at the time of visit only.
9. Request your preferred doctor when you make your appointment. Please also try to be flexible when we have to treat many sick patients.
10. Referrals to a specialist or hospital will be made according to the degree of urgency and availability of the specialist. Please be aware that some specialists are booked weeks or months in advance. Failure to show for a referred appointment will further delay services and can make it much harder for your child to receive necessary care.
11. Finally, taking your child to after-hours clinics or ERs for non-urgent matters will only compromise quality of care and increase waste. We strongly advise against using after hours clinic for illnesses that can wait until next morning.

I have read and understand these office policies. I understand that these policies apply to all children for whom I am responsible that are treated at Iberia Pediatrics.

DATE: _____ **_____**

SIGNATURE OF GUARANTOR/LEGAL GUARDIAN

Iberia Pediatrics FINANCIAL POLICIES

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, especially regarding vaccines, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Missed appointments: Our policy is to charge a **$30 fee for missed appointments** not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you.

Insurance: We participate in most insurance plans, including Bayou Health Plans. If you are not insured by a plan we do business with, if your coverage cannot be verified at the time of service, or if our physician is considered "out of network" on your plan, payment in full is expected at each visit. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: We will make an honest effort to verify that the services and vaccines we provide are covered by your insurance. However, there are times when we learn after the service has been provided that it was in fact not covered. Knowing your insurance benefits is **your** responsibility. Please contact your insurance company with any questions you may have regarding your coverage. You are responsible for all non-covered services!

Vaccines: We give your child vaccines at your request with the expectation that you or your insurance company will reimburse us in a timely manner. For privately insured patients, these vaccines have already been purchased by us at great expense so that they will be available for your child. If for any reason the vaccine reimbursement is denied in part or in full, you are responsible for the charges. If you are not in agreement with this policy, please let us know so that we can provide you with other options for your child's immunizations.

Claims submission: As a courtesy to our patients who have insurance policies that we have verified, we will file insurance claims on your behalf and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. <u>If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.</u> If a payment made by you is later paid by your insurance company, we will promptly refund or credit you for any overpayment.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and your child(ren) may be discharged from the practice.

I have read and understand the payment policy and agree to abide by its guidelines. I understand that these policies apply to all children for whom I am financially responsible that are treated at Iberia Pediatrics.

DATE: _____ _____

SIGNATURE OF GUARANTOR/LEGAL GUARDIAN

Iberia Pediatrics

Please select patient(s) Primary Provider: ☐ BOUDREAUX ☐ FAUGOT ☐ RADER

Select your preferred way to receive appointment reminders: ☐ Email ☐ Text Message ☐ Voicemail

CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
Mailing or Street Address (Where you receive your mail):	Preferred Phone #:		
City, State, & Zip Code:	Secondary Phone #:		
Email Address: ☐ Mom ☐ Dad			
RACE: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other: _____			
ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic	PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____		

:: PLEASE LIST ADDITIONAL CHILDREN THAT YOU ARE ALSO RESPONSIBELE FOR THAT ARE PATIENT'S HERE ::

CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
RACE: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other: _____			
CHILD'S FULL LEGAL NAME: (Print Please)	Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female
RACE: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other: _____			

::: GUARANTOR(S)/LEGAL GUARDIAN(S) INFORMATION:::

MOTHER'S NAME: (Print Please)	Date of Birth:	Social Security #:	
Mailing or Street Address (If different from above):	Home #:	Work #:	Cell #:
MOTHER'S EMPLOYER:			
FATHER'S NAME: (Print Please)	Date of Birth:	Social Security #:	
Mailing or Street Address (If different from above):	Home #:	Work #:	Cell #:
FATHER'S EMPLOYER:			

::: EMERGENCY CONTACT: *(OTHER THAN PARENT(S))* :::

NAME:	Relationship to Patient:	Home #:	Cell #:

::: INSURANCE ONLY! **PRIMARY Cardholder's Information :::

NAME:	Relationship to Patent:	Date of Birth:	Social Security #:
Mailing or Street Address (If different from above)	Home #:	Work #:	Cell #:

Primary Insurance:		Secondary Insurance (If available):	
Policy#:	Group#:	Policy#:	Group#:

****WE ASK THAT PRESENT A COPY OF YOUR INSURANCE CARD(S) AND ID ON EVERY VISIT.****

Iberia Pediatrics
Lynzie E. Boudreaux, M.D. Maurice B. Faugot, M.D. Allison Z. Rader, M.D.
295 INDEST STREET NEW IBERIA, LA 70563
PHONE: (337) 365-0268 or (337) 365-5437 FAX: (337) 369-6922

AUTHORIZATION FOR CHARGES AND BENEFITS

CONCERNING PHYSICIAN CHARGES:

I understand that there may be charges for services that may not be fully covered by my insurance. I also understand that services are rendered and charged to me, not my insurance carrier, at the time of service. Therefore, acting as legal guardian of this child, I understand that I am personally responsible for all charges, including those not fully covered by insurance.

AUTHORIZATION OF BENEFITS:

I hereby authorize and request my insurance company to pay IBERIA PEDIATRICS directly for any benefits as described in the accompanying payment policy, but not to exceed the reasonable and customary charge for those services.

CONSENT FOR MEDICAL CARE

CONSENT TO TREAT:

Consent is hereby given, voluntarily and knowingly by the undersigned patient, (who if a minor, is joined in such consent by the undersigned parent or legal guardian to the performance of invasive and other procedures, treatments, blood tests, or examinations which I or my child or children may receive while patient(s) with **IBERIA PEDIATRICS INC**. from members of the medical and employee staff which they, or any of them, in their best judgment may deem proper for my best interest. I further authorize any and all other procedures or treatments the Clinic deems necessary in the best interest of patient(s) care. I hereby authorize disposal of any specimen taken from my body during my care.

I attest that I have read the above and am aware of its content and also that this consent covers all patient(s) / famly members listed on registration sheet.

DATE: _____

_____

SIGNATURE OF GUARANTOR/LEGAL GUARDIAN

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PERMISSION TO TREAT AND DISCUSS MEDICAL INFORMATION

Your child's medical information is confidential and cannot be released without your authorization. Please list all persons who have permission to bring your child(ren) for medical care at Iberia Pediatrics. Those listed below will be authorized to receive both written and verbal medical information from Iberia Pediatrics regarding your child(ren).

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

Please list the child(ren) for whom you are giving authorization:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

I understand that my child(ren)'s medical information is confidential and cannot be released without my authorization. I give permission to those persons listed above to give and receive medical information regarding my child(ren) to Iberia Pediatrics providers and staff.

TODAY'S DATE: _____

PARENT/GUARDIAN'S NAME: (Please Print) _____

PARENT/GUARDIAN'S SIGNATURE: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(OFFICE USE ONLY)

By signing this authorization, I authorize _____ to use and/or disclose certain
Doctor/Practice
protected health information (PHI) about the patient(s) listed below to _____
Doctor/Practice
This authorization permits them to use and/ or disclose the following individually identifiable health information

(specifically describe the information to used and disclosed, such as date(s) of services, type of services,

level of detail to be released, origin of information, etc.)

- ☐ ENTIRE CHART
- ☐ IMMUNIZATIONS
- ☐ OTHER: _____

The information will be used or disclosed for the following purpose:

- ☐ Continue Care and Treatment
- ☐ OTHER: _____

This authorization will expire one year from this date: _____

I do not have to sign this authorization in order to receive medical treatment from IBERIA PEDICATRICS. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Office at their office.

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN **Relationship to Patient(s)**

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN

Please list child(ren) to whom this form applies:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____