NORTH SCOTTSDALE
PEDIATRICS
A Division of Arbor Medical Partners

18+ years CONSENT TO SHARE HEALTH INFORMATION WITH PARENTS

Patient's Name_____ Date of Birth _____

I understand that by law 18 year olds are adults. As adults, they have the right to keep health records confidential *(regardless of who pays for their insurance or whether they live at home)*.

Providers at North Scottsdale Pediatrics believe parents should be partners in their children's care at every age. However, it is up to the patient to whom he/she gives permission to share privileged information. Therefore, we ask all of our patients over the age of 18 to consent as follows:

I give permission to the healthcare providers at North Scottsdale Pediatrics to speak with my parent(s)/legal guardian(s) at any time regarding any of the following:

☐ My healthcare conditions

☐ My health status, excluding sensitive conditions[1]

☐ Payment Responsibility

Consent given to:

☐ Mother_____

☐ Father_____

☐ Step-Mother_____

☐ Step-Father_____

☐ Other _____

☐ I do NOT give my consent to any provider to speak with my parents about any of my healthcare conditions

I understand that I may change my mind at a future time and rescind this authorization.

_____ _____

Patient's signature Today's date

[1] ***Sensitive conditions include alcohol or drug use, sexual activity, pregnancy or sexually-transmitted diseases, and mental health issues.***

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name _____

Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

NORTH SCOTTSDALE PEDIATRICS

A Division of Arbor Medical Partners

FINANCIAL POLICY 2018

Thank you for choosing North Scottsdale Pediatrics a division of Arbor Medical Partners, LLC for the care of your child. This Financial Policy is an important part of your child's care. Due to increased insurance company demands, we ask you to read and agree to the following NSPEDS provisions:

Private Pay Patients: If you have no insurance coverage, full payment is expected at the time of service. If you pay in full, we are pleased to offer you a 20% discount on the visit only.

Insurance: As a courtesy, NSPEDS will file your claim to your insurance company; however, at the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted through our patient portal. We advise you to contact your insurance company in advance to verify coverage for specific benefits such as well checks, immunizations, behavioral visits, and lab services. If you have any **"Out of Network Benefits"** with a plan we are not contracted with, we will bill your insurance company as a courtesy. Any Patient responsibility will be billed to the guarantor on file.

Fee Schedules: Our prices are dictated by our insurance contracts. It is a violation of our contractual agreements with your insurance plans to discount or waive charges for coverage, etc.

Payment Options: By signing the Credit Card Authorization Form, you understand that as soon as your EOB (Explanation of Benefits) is received by our office from your insurance plan, your credit card will be charged for the balance due on your account, per your insurance contract. In the event you opt not to sign the Credit Card Authorization Form and your balance is not paid within 14 days, you will incur a $25.00 service fee for each statement that we generate that shows a balance on your account.

Statements: Statements are generated to your portal account. If you do not have a portal account, your statement will be mailed to the address that we have on file for you. For your convenience and for ease of processing, we would prefer that you utilize our credit card processing service, where online payments can be made through our new and expanded portal, or our website.

Outside Collections: If your balance has not been paid to NSPEDS within 120 days, your account will be turned over to our outside collection agency. Thereafter, within 60 days, if your balance has not been paid, dismissal from NSPEDS will occur. Any fees incurred from the collection agency may be assessed to your account.

Laboratory Fees: You will receive a separate laboratory fee for their services. Any lab services that are not covered by your insurance will be your responsibility.

Address and insurance changes: Please let us know if your address, phone numbers, insurance, etc., change, so that your information is always current and accurate in your child's records. This can also be updated through our Patient Portal.

Authorization for medical treatment of a minor: Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. If the accompanying adult is not the parent/guardian, we will require a "Consent to Treat Form" be filled out. The person bringing in the child for medical treatment will be held responsible for payment at the time services are performed.

Divorce/Custody: We cannot and will not become involved with parental billing disputes in divorce and/or custody cases. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at time of service. NSPEDS **DOES** require documentation from the court for all legal matters that relate to your child's care; i.e., custody, medical decisions, medical record access, etc.

Cancellations/No Shows: If you cancel your appointment with less than a 24-hour notice or do not show for the appointment, a $50 fee will be charged to your account.

AHCCCS Recipients - Please note that failure to disclose your AHCCCS eligibility will result in your financial responsibility for services rendered at this office.

I have read and understand NSPEDS (a division of Arbor Medical Partners, LLC) Financial Policy and agree by its terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by Arbor Medical Partners, LLC. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

Patient Name & Date of Birth: _____

Responsible Party Name (Please Print): _____

Your Signature: _____ Date: _____