PLEASE LIST ALL CHILDREN IN YOUR FAMILY BELOW

Child's Name	DOB	M/F	Race	Ethnicity
1)		M/F		
2)		M/F		
3)		M/F		
4)		M/F		
5)		M/F		

Patient's Address: _____City:_____

State:_____Zip:_____ Best Contact Number:_____

Emergency Contact: _____ Phone Number: _____

Relationship to Family: _____

Pharmacy Name & Address: _____

Father/Guardian Information: o Single o Married o Divorced o Widowed

First:_____Last: _____DOB:_____

SSN:_____E-Mail Address:_____

Address (*if different then patient*):_____City:_____

State:_____Zip:_____ Best Contact Number: _____

Employer Name: _____

Mother/Guardian Information: o Single o Married o Divorced o Widowed

First:_____Last: _____DOB:_____

SSN:_____E-Mail Address:_____

Address (*if different then patient*):_____City:_____

State:_____Zip:_____ Best Contact Number: _____

Employer Name: _____

Primary Insurance

Insurance Company : _____ Member #: _____

Group#: _____ Policy Holder's Name _____

Secondary Insurance

Insurance Company : _____ Member #: _____

Group#: _____ Policy Holder's Name _____

FINANCIAL AGREEMENT

• Full payment is expected and required at the time services are rendered and for all past due balances unless prior financial arrangements have been made with billing staff. **It is the policy holder's responsibility to know whether or not our office is in or out of network. Our office cannot guarantee this information. If you are unsure, please call your insurance to verify prior to your visit.**
As of 1/1/25, we will add a $10 charge to your account for any copays not paid at the time of service.

• Payment is due regardless of who brings the child in for the service. This includes step parents, grandparents, caregivers, etc. It is the parent/guardian's responsibility to notify the office of any address, phone, or insurance changes. **Please have your insurance card with you at every visit.** I understand that I am responsible to pay for services including reasonable attorney fees and cost of collection in the event of a default. A payment plan can be made to avoid your account being turned over to a collection agency. If the account is turned over to collections, a 20 % fee or $50.00 *(whichever is greater)* will be assessed in addition to the total balance of the account payable by the guarantor. **If your account is in collections, your child cannot be seen until the balance is paid in full.**

• For families in which parents are separated and/or divorced, the parent bringing the child to the office is authorizing treatment and is, therefore, the parent responsible for payment on the date of service. If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. We can provide a copy of the claim or receipt of charges to the authorizing parent at each visit upon request to assist in the collection of fees from the other parent. It is the responsibility of the authorizing parent to convey to the other what was discussed at the appointment. If there are further questions or clarification is needed, please call our office to discuss further. Our office cannot call to update a parent at every visit.

• Insurance must be provided and active in order to utilize your benefits. If no insurance is active for the visit, the patient will be charged the discounted self-pay rate which is due prior to leaving your appointment. Once insurance is corrected or reinstated, we will process your claim through insurance. Once payment is received from your insurance, we will then process a refund for the payment made at the time of service. This includes newborns not added to the insurance within 30 days of birth.

• Acceptable forms of payment include Cash, Check, Visa, MasterCard, American Express, Discover, Apple Pay & Google Pay. A fee of $25.00 will be assessed to all returned payments.

NO SHOW OR CANCELLATION FEES

A $50.00 fee applies to all physician visits, including telehealth visits, cancelled less than 24 hours prior to appointment time and no shows to any scheduled appointments. A **$20.00** fee applies to all nurse visits when missed. If your appointment slot is missed by 15 minutes or more, your appointment will be rescheduled and the no show charge will still apply.

If a denial of payment is received from my insurance carrier, the charge will become my responsibility. My financial responsibility explicitly includes "non-covered" services including, but not limited to:

* All immunizations
* Laboratory tests performed in the Doctor's office
* After-hours, Weekend, Walk-in, and Holiday Visit Charges
* Vision testing
* Hearing testing
* Physical Exam - Well child visits requested beyond allowances of insurer
* Developmental screening, Health Risk assessments
* Adult Postpartum screening
* Visits and immunizations related to travel
* Preparation fee for forms, letters and medical records (Medical Records are $1/page or $100 for the entire record whichever is less)

By signing this form, I am agreeing to and understand the above financial policies. I hereby authorize the release of medical records to my insurance company, as may be necessary for the purpose of reimbursement. I realize that I am ultimately responsible for any and all services rendered to me (my child) regardless of any insurance determinations.

Name : _____

Date : _____

ADVANCED BENEFICIARY NOTICE

We pride ourselves on providing only the highest quality care for your child and do this by following many of the American Academy of Pediatrics clinical guidelines and other trusted sources for evidenced-based clinical outcome information.

You can verify with your insurer which services it covers and which it does not. Performing tests in-office is faster and more efficient than sending tests out to labs, and performing screenings such as hearing and vision tests avoids incurring the inconvenience and expense on your part to refer you to a specialist for these things. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings and tests as we, your trusted providers of care, deem necessary.

PCR Strep - $35.00
PCR Flu Test - $55.00
PCR COVID/Flu/RSV - $75.00
Urinalysis - $10.00
Hemoglobin - $10.00
Allergy Testing - $200.00
Pregnancy Testing - $10.00
Vision - $20.00
OAE - $20.00
Developmental Screenings (ADHD, Postpartum, Developmental, Anxiety, etc) - $10.00

If you do not wish for your child to have any of the above tests or screening exams, please inform the staff at the beginning of your visit. Please realize that in doing so it may be necessary to send a test to an outside lab, refer you to a drawing site, or schedule a visit with a specialist.

I _____ parent/guardian of _____
was made aware that the above listed in office testing may not be covered by my insurance and I do not wish to call my insurance company to verify. I would like to go ahead with testing and understand that I am financially responsible for any in office testing not covered by my insurance as listed below. This waiver will expire yearly.

Parent/Guardian Signature _____

Date _____

AUTHORIZATION FOR TREATMENT
I authorize Live Well Pediatrics, PC to provide treatment to my child.

ASSIGNMENT OF BENEFITS
I authorize my insurance company to pay and hereby assign directly to Live Well Pediatrics, PC all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing. I authorize Live Well Pediatrics, PC to submit and appeal any claims on my behalf. I authorize payment of medical benefits directly to Live Well Pediatrics, PC for services described.

DISCLOSURE OF PROTECTED HEALTH INFORMATION
My insurer may share my past, current and future health, medical and account records with Live Well Pediatrics, PC about services I've received and other care providers unrelated to Live Well Pediatrics, PC. Including but not limited to insurance, laboratories, or other providers requesting information who are being consulted with and/or I am being referred to in connection with my current treatment. Insurance companies may request information for the purpose of determining benefits for services provided. Also, reference laboratories may request information for billing purposes. These records may be used by Live Well Pediatrics, PC as needed to manage or coordinate my care and to improve the quality of that care. By signing this form, I am consenting to treatment, and agreeing to all above policies. I understand this authorization will remain in effect until I revoke it in writing. I authorize release of copies of pertinent medical records to providers outside of Live Well Pediatrics, PC.

REFERENCE LABORATORY SERVICES
I understand that Live Well Pediatrics, PC utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Live Well Pediatrics, PC and to provide demographic information as necessary for billing purposes.

IMMUNIZATIONS

Live Well Pediatrics, PC supports vaccination according to the CDC and AAP standard immunization schedule. Vaccines are safe and effective in preventing diseases and health complications in children and young adults. I consent to following the approved AAP Pediatric Preventative Vaccination Schedule. ***(If you have any questions regarding this, a schedule can be provided at your request).*** **Our office does not accept patients who do not vaccinate and would ask that they seek medical treatment elsewhere.**

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

- Conduct, plan, and direct my treatment and follow-up care 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 acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 at the address below to obtain a current copy of Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I, a patient, parent or legal guardian of a minor, understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Responsible Party:_____ Date: _____

Patient's Name : _____ Patient's Name : _____

Patient's Name : _____ Patient's Name : _____

CREDIT CARD ON FILE: BILLING AUTHORIZATION FORM

Please note, the card provided must be a credit card, not a debit card, to avoid problems related to non-sufficient funds transactions.

Information to be completed by cardholder:

The undersigned agrees and authorizes Live Well Pediatrics, PC to charge the credit card indicated below for any account balances which include, but are not limited to, copays, coinsurance, deductibles, no show appointments, non-covered services, and forms.

Patient's Name:_____

Patient's Name:_____

Patient's Name:_____

Patient's Name :_____

Name (as it appears on card):_____

Type of Credit Card: o Mastercard o Visa o Discover o American Express

Card Number:_____

Expiration Date: _____ Billing Zip Code: _____

Security Code: _____

I, _____ authorize Live Well Pediatrics, PC to process the above credit card as "Signature on File" for any open balances on my account. Any balance on my account that is outstanding will be automatically charged to the credit card on file. I understand this authorization will expire upon expiration of the credit card.

_____ _____

Cardholder's Signature Date

CONSENT FOR ELECTRONIC COMMUNICATION

Following your visit, Live Well Pediatrics, PC, or its designated vendor, may contact you by telephone, text message, email, mobile application, or US mail to request feedback on your experience and/or to communicate with you regarding your personal, or your dependents, outstanding invoice(s). By signing below, you confirm your understanding and agree to be contacted in this manner in connection with today's visit and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing. This includes responding via text message. Standard telephone/text charges may apply if we contact you. You further agree that, based on your feedback, we may utilize your statements or comments, on an anonymous basis, on our website to provide reviews of our care that might help prospective patients choose our services.

Signature: _____

Name: _____

Date: _____

Children's Names: _____

_____

_____

_____

_____