Northpoint
PEDIATRICS

# REGISTRATION PACKET

Thank you for choosing Northpoint Pediatrics for the care of your child. This packet contains the following items that must be completed:

- Consent for Communication via Electronic Mail – *information only*
- Failed and Cancelled Appointment Policy – *information only*
- Patient Registration Form – *please complete fully, sign and date*
- Patient Authorization Form – *please read, initial, sign and date*
- Northpoint Pediatrics Financial Agreement – *please read, sign and date*

Please bring completed paperwork (including both pages of the Northpoint Pediatrics financial agreement) to your first visit.

# Consent for Communication via Electronic Mail.

I give my consent for Northpoint Pediatrics business office staff to communicate with me via email in regard to my child(ren).

By providing this email address the providers and staff at Northpoint Pediatrics will assume that they are communicating ONLY with the legal parent or legal guardian of the patient named above. Once the information to be communicated is sent to the parent's email address, the legal parent/legal guardian of the patient will be responsible for maintaining the security of the information. The legal parent/legal guardian must recognize that the information transmitted cannot be considered secure and that there is some risk to the patient that their personal protected health information may be accessed by others.

***Northpoint Pediatrics does not provide any medical advice or treatment via e-mail***

**All questions regarding the care and health of your child should be directed to your primary care doctor by calling 317-621.9000.**

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# Failed and Canceled Appointment Policy

Missed appointments are a loss to everyone, please cancel ill and checkup appointments within the time frame listed below, or a charge may be assessed.

**CANCELLING ILL APPTS:** Please cancel at least 2 hours before your appointment.

**CANCELLING CHECK-UP APPTS:** Please cancel by 4:30 p.m. the day before your appointment. *Monday appointments must be cancelled by 3:30 p.m. on Friday.*

**CHARGES FOR <u>CANCELLATION WITHOUT SUFFICIENT NOTICE</u> AND <u>FAILED APPOINTMENTS</u>**

$0……..First missed appointment or cancellation with insufficient notice.

$50……Second missed appointment or cancellation with insufficient notice.

$100……..Third missed appointment or cancellation with insufficient notice.

$100……..Subsequent missed appointments or cancellations with insufficient notice.

# Northpoint Pediatrics Patient Registration Form

| | | | |
|---|---|---|---|
| **Patient's Full Name** | | | Acct# |
| Date of Birth | | BOY ☐ GIRL ☐ | PCP |
| **Patient's Full Name** | | | Acct# |
| Date of Birth | | BOY ☐ GIRL ☐ | PCP |
| **Patient's Full Name** | | | Acct# |
| Date of Birth | | BOY ☐ GIRL ☐ | PCP |
| **Patient's Full Name** | | | Acct# |
| Date of Birth | | BOY ☐ GIRL ☐ | PCP |

**PLEASE CIRCLE ONE - Children live with both parents, mother, father, other - please list_____**

| | | | |
|---|---|---|---|
| Father's Name / Domestic Partner - circle one | | Mother's Name / Domestic Partner - circle one | |
| SSN | Date of Birth | SSN | Date of Birth |
| Street Address | | Street Address | |
| City, State, Zip | | City, State, Zip | |
| Employer | Occupation | Employer | Occupation |
| Home Phone | Work Phone | Home Phone | Work Phone |
| Cell Phone | Pager | Cell Phone | Pager |

| | |
|---|---|
| **Insurance Policy Holder's Name:** | **Relationship to child** |

| | | | |
|---|---|---|---|
| Step Mother's Name / Domestic Partner - circle one | | Step Father's Name / Domestic Partner - circle one | |
| SSN | Date of Birth | SSN | Date of Birth |
| Street Address | | Street Address | |
| City, State, Zip | | City, State, Zip | |
| Employer | Occupation | Employer | Occupation |
| Home Phone | Work Phone | Home Phone | Work Phone |
| Cell Phone | Pager | Cell Phone | Pager |

**Parental Relationship - please circle one - Married Separated Divorced Never Married Widowed**

| | | |
|---|---|---|
| **LEGAL PARENT / LEGAL GUARDIAN SIGNATURE** | **PRINTED NAME** | **DATE** |
| **X** | | |

| | | | |
|---|---|---|---|
| Today's Date | Entered by: | | |

# Northpoint Pediatrics Patient Authorization

**Please read, initial, and sign below.**

_____ (Initial) **Consent to Treat:** I have the legal right to consent to medical treatment for this patient and voluntarily authorize the medical examination, treatment and diagnostic tests that providers of Northpoint Pediatrics believe are necessary for my child.

_____ (Initial) **Privacy Policy**: I acknowledge that I have received a copy of the Northpoint Pediatrics Privacy Policy. *Available on our web site and in the office.*

_____ (Initial) **Consent for Electronic Communication:** I have read and agree to the Northpoint Pediatric consent for communication via electronic mail. Due to many employers and businesses blocking incoming email from non-approved email addresses please provide your personal email address.

Email address (personal email address only) _____

Email address (personal email address only) _____

_____ (Initial) **Failed and Canceled Appointment Policy Fee**: I acknowledge that I have received, reviewed, and agree to comply with the Northpoint Pediatrics Failed and Canceled Appointment Policy and agree to pay any fees incurred from failure to comply.

_____ (Initial) **Financial Policy**: I acknowledge that I have received, reviewed, and agree to comply with the Northpoint Pediatrics Financial Policy.

_____(Initial) **Consent Withdrawal**: I understand I am able to withdraw my consent at any time by contacting Northpoint Pediatrics in writing at 8101 Clearvista Parkway, Suite 186, Indianapolis, IN 46256.

Patient Name: _____DOB: _____CHART # _____

Patient Name: _____DOB: _____CHART # _____

Patient Name: _____DOB: _____CHART # _____

Patient Name: _____DOB: _____CHART # _____

Parent/Guardian name (Print):_____

Parent/Guardian Signature: _____

Today's Date: _____

**Relationship to Child: _____Today's Date: _____**

****Office Use Only – Form entered by _____ Date entered _____**

# Northpoint Pediatrics Financial Agreement

This policy explains our practices regarding insurance billing, copayments, and patient billing. Your signature on the signature sheet confirms that you have read this policy and agree to be held financially responsible for all charges on your child's account.

## Routine Care

We follow The American Academy of Pediatrics schedule of visits for routine well child care (see the schedule on the web at aap.org under preventive schedule). This schedule *may not* be the same as the one your insurance company follows.

Additional services are separate charges from the wellness exam and have separate fees – for example immunizations, vision and hearing screening, urinalysis, lead and cholesterol screenings, developmental screenings (ASQ, MCHAT), depression and anxiety screenings (PHQ9, GAD7). This is not an exclusive list of charges and other charges may apply.

## Coding and Documentation Guidelines

Northpoint Pediatrics physicians follow the **AMA CODING AND DOCUMENTATION GUIDELINES**. If your child comes in for a well child visit, but in the course of this routine visit "an abnormality/ies is encountered or a preexisting problem is addressed" the appropriate office/outpatient problem-oriented evaluation and management, E/M service will be coded in addition to the preventive code; which may result in additional charges. Examples of this would be patients with asthma and ADD/ADHD coming in for a well child exam or a child with an illness at the time of the well visit. Insurance companies process these claims according to their policy guidelines and the patient may have a balance due for the unrelated office visit.

## Lab Work, Testing and Specialty care

Many insurance plans require that their members use the specialists, laboratories and outpatient facilities that they have contracts with. Please be familiar with your policy and advise us where we should direct you for any additional tests, screening or procedures if your insurance does not permit them to be performed in the office setting. Labs will be sent to Mid America Clinical Laboratories. (MACL) unless you inform us otherwise.

## ER/Urgent Care Facility Services

Most insurance company agreements require pre-authorization for using emergency services for non-life threatening conditions. You must notify your insurance company and primary care doctor prior to seeking medical care from an ER, Med Check or Urgent Care facility if possible. If care is sought out in a life threatening or emergent situation, contact Northpoint Pediatrics within 24 hours so that we may obtain authorization for your visit.

## Newborn Hospital Charges

Newborn charges are patient responsibility until the baby has been added to the insurance. We will file hospital charges to your insurance company after you have provided proof of insurance coverage. If you fail to contact our office within insurance filing limits, the charges will remain patient responsibility.

**Newborn Coverage is NOT automatic!** Most insurance plans only allow 30 days after the baby's birth to add your newborn to the policy. You must call your benefits department or your insurance company to add your baby to the policy.

## Insurance and Payments

A. By signing you agree that you are ultimately responsible for all payment obligations arising out of the treatment or care provided by Northpoint and guarantee payment for these services, including without limitation all deductibles, co-payments, co-insurance amounts or any other charge not otherwise covered by insurance. Your obligations shall be continuing, absolute and unconditional, and shall remain in force and effect until any and all obligations are fully paid. There shall be no obligation on the part of Northpoint at any time to first exhaust its remedies against patient, any other party, or any other rights.

B. We shall submit claims to your insurance carrier for payment as a courtesy to you. Payment of all co-payments, unsatisfied deductibles, out of network services and for services not covered by insurance are due on the date services are rendered. You shall pay an additional $10 processing fee if co-payments are not paid on the day the service is provided.

C. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services from Northpoint, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received from Northpoint are not medically necessary and/or not

covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

D. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled.

E. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Northpoint, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Northpoint and associated physicians, staff, and hospitals to release patient information acquired in the course of examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to the treatment (including itemization of any charges and payments on the account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Northpoint does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

F. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Northpoint until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Northpoint to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are financially obligated, and any remaining balance will be returned to the payor.

G. We recognize that there are times when you cannot pay your balance in full within the 30-day period. We offer payment arrangements for special circumstances. Please contact our Patient Accounts department at (317) 621-9183 to discuss eligibility for a payment plan contract.

H. Whether or not you have insurance or are self-pay, payment of any account balance is due immediately upon presentment. If any balance on your account is over thirty (30) days past due, your account will be in default and may be referred to a collection agency without notice to you. If your account balance ages 90 days (3 months) past the due date (and is not on a payment plan) - your doctor will request that your family seek medical care elsewhere.

I. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Northpoint has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) all court costs and fees (but only to the extent allowed by law); and (ii) **a collection fee to be charged under separate agreement with a third-party collections agency equal to 22% of the total balance due on your account which shall be added at the time of the referral to the third party collection agency.** If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record.

## Authorization to Contact

You authorize Northpoint and its employees, affiliates, agents, servicers, collection agencies and others calling at their request or on their behalf to contact you by mail, email, text message or telephone call at any address, email or telephone number (i) you have provided to us (ii) from which you have called us, or (iii) which we obtain and believe we can reach you at. We may contact you in any way, such as calling, texting, using an automated dialer or using pre-recorded messages. We may contact you on a mobile, wireless, or similar device, even if you are charged for it by your provider.

| _____ | _____ | _____ |
|---|---|---|
| Parent Name | *Parent Signature* | Date |