Mundelein Pediatrics, S. C.
Pediatrics - Adolescents
1170 E. Belvidere Road • Suite #106
Grayslake, IL 60030

Jennifer Devaney, M.D.
Karin Kallwitz, M.D.
Kathy Seskiewicz, M.D.
Diana Trew, M.D.
Heidi Kramer, M.D.
Jeremy Messinger, A.P.N., P.N.P.
Maral Mjukian, A.P.N., P.N.P.

Date of Service_____

Re: _____
(Child's Name and DOB)

Waiver Form

Please read through this waiver form, find the section that applies to you and if applicable, sign and date.

SELF-PAY PATIENTS WITHOUT INSURANCE

If you do not have any health insurance, you are a self-pay patient. Please sign the waiver below

I acknowledge that currently **I DO NOT** have any health insurance for my child(ren). Furthermore, I do acknowledge that if insurance does become available to me at a later date, this visit will not be filed retroactively. I will notify this office of any changes in my health insurance status.

_____ _____ _____
Parent Name **Signature** **Date**

PENDING INSURANCE WAIVER

You have just informed Mundelein Pediatrics, S.C. of one of the following, **Please Circle**: (1) That you now have a new insurance company and you **DO NOT** have your cards yet. (2) Based on the insurance information you provided, our eligibility database shows that you are not with the appropriate site or primary care physician. (3) You have a newborn baby that has not received an insurance card yet. In order for us to submit the claim to the insurance company, we must have a copy of your child(ren's) insurance card. We need a legible copy of the front and the back of the card including the policy holder's name and insurance I.D. number. When you give us your card, ***please indicate that your child has been seen without insurance with the dates of service so that they can be submitted to your insurance company***, otherwise those previous dates of service may not be submitted. We must submit our office visit claims to the insurance company within 30 days. Since your insurance company will not accept any claim after 30 days, you will be completely responsible to pay the entire balance in full if we do not receive your card on time. **No exceptions**. We also have the right to deny services for current or future visits if this is not taken care of. This also applies for your visits if you have the wrong site number or primary care physician listed on your card. If proof of eligibility is not there, or one of our physicians is not listed as the primary care physician, you will be responsible for the entire visit. **No exceptions**.

Please indicate below the insurance your child will have

☐ **Commercial Insurance** ☐ **Medicaid/IPA Plans**

Please be advised we **DO NOT** accept families with Medicaid/IPA Plans that became effective after 01/2017.

Parent Name_____ **Signature**_____ **Date**_____

Sincerely,
Mundelein Pediatrics, S.C.

Revised 03/09/2020

Mundelein Pediatrics

Patient Information sheet **Today's Date:** _____

First Name: _____ Middle initial: _____ Last Name: _____ Sex: ☐ M ☐ F

Date of Birth: _____ E-mail address: _____

Address: _____
ADDRESS CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work: _____

Parent(s)/Guardian(s) Name:
_____ Occupation: _____

Insurance Information: _____
SUBSCRIBER NAME DOB INSURANCE CARRIER GROUP ID

If minor, who is responsible party? _____

Emergency Contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

Additional Health Care Professionals (Specialist) involved in patient's care:

_____
NAME SPECIALTY PHONE NUMBER

.....

Primary Race (check one):

☐ White/Non-Hispanic	☐ Asian	☐ Other Pacific Islander
☐ Hispanic	☐ Native American	☐ Other Race
☐ African American/Black	☐ Native Hawaiian	☐ Refused to Report

Primary Language Spoken at Home (check one): ☐ English ☐ Spanish ☐ Other: _____ Interpreter needed? ☐ Yes ☐ No

Who is the Primary Caregiver (provides day –to-day care) for the Patient?

_____
NAME RELATIONSHIP TO PATIENT

Who is the Legal Guardian (Individual designated by the patient, family or court to make health care decisions for the patient if the patient is unable to do so) for the Patient?

_____
NAME RELATIONSHIP TO PATIENT

Preferred pharmacy: _____
NAME ADDRESS PHONE NUMBER

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorized us to do so.*

IMMUNIZATIONS: *Our electronic medical records program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.*

Signature: _____ *Date:* _____
PATIENT GUARDIAN RELATIONSHIP TO PATIENT

- ***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 the 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.

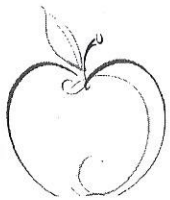
- ***Copy of Notice:*** You have a right to obtain a paper copy of this notice, even if you originally received the notice electronically. We have also posted this notice at our office.

- ***Complaints:*** If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (847)548-7337. 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.

Mundelein Pediatrics S.C.

1170 E. Belvidere Rd.
Grayslake, IL 60030
Phone: 847.548.7337
Fax: 847.548.9909



Mundelein Pediatrics S.C.

Notice of Privacy Practices

Health Insurance Portability Accountability Act

Our Promise to You, Our Patients

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

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 and Acknowledgement that you have received this Notice.

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

We are required by federal 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 breach of your unsecured PHI.

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

- ***Treatment:*** 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.

- ***Payment:*** 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.

- ***Health Care Operations:*** 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.

- ***Legal Requirements:*** 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:

  - ***Public Health:*** 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.

  - ***Health Oversight Activities:*** 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 benefits 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 office, 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 the 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 copies and mailing them to you, if you ask us to mail them.

MUNDELEIN PEDIATRICS, SC

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HIPAA Release Form
Acknowledgment & Authorization Form

Patient Name _____ DOB _____

Notice of Privacy Practices

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

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of the Notice will be provided upon request or available to me on our website. We may use your protected health information (PHI) for the following:

- Treatment: your protected health information may be used or disclosed by those who are involved in your care.
- Payment: we may use and disclose PHI so that we can receive payment for the treatment services provided to you.
- Required by law: your PHI will be used or shared as required and allowed by law.

Phone Message and Contact Authorization

Do the physicians and staff of Mundelein Pediatrics have your permission to:
[ ] Leave a message with detailed information
[ ] Leave a message with a call back number

Authorized Individuals

I give authorization to the doctors and staff of Mundelein Pediatrics to discuss my child's protected health information and financial information with the following people

*Please list yourself as well as anyone else we may contact.

Name	Relationship to patient	Phone Number

X _____

Signature of Patient (If 18 years or older), Parent or Guardian Print Name Date

Please Continue on Back →

PERMISSION FOR MEDICAL TREATMENT /INFORMATION AUTHORIZATION

I, _____ authorize the methods of communication of my child's

_____ protected health information as indicated below.
Patient name and DOB

I understand that under the HIPAA guidelines, the patient's information is held confidential unless authorized by my signature, except for payment operations. The following person(s) can request, pick up records, prescriptions, take messages regarding my child's health and discuss my child's health with the Doctor and/or their staff:
PLEASE PRINT

1._____ Relationship_____ Cell_____
PLEASE PRINT NAME

2._____ Relationship_____ Cell_____
PLEASE PRINT NAME

3._____ Relationship_____ Cell_____
PLEASE PRINT NAME

4._____ Relationship_____ Cell_____
PLEASE PRINT NAME

Mundelein Pediatrics S.C. is authorized to communicate Protected Health Information such as lab results, physician messages or appt information.

The above named have my permission to bring my child to be seen for an appointment and receive treatment (including immunizations if needed).

They will be advised that a photo ID will be required when they bring my child in.

_____ _____
Signature Date

Mundelein Pediatrics

Patient's Name: _____ DOB: _____

FINANCIAL POLICY

Thank you for choosing Mundelein Pediatrics, S.C. (MP) as your child's healthcare provider. We are committed to provide your Child (ren) with the best possible care. Our goal is to provide and maintain a successful physician-patient relationship. In order to reduce potential misunderstandings, our practice has adopted the following financial policy and we ask that you review and sign this agreement.

Parent/Patient Responsibilities

➢ Payments

The patient is expected to present an insurance card at **each** visit. Please notify us of any changes to your insurance or personal information (address, phone #, email, insurance carrier, etc.) All copayments and past due balances are due at the time of service unless previous arrangements have been made with our business office.

➢ Professional Services Rendered

If your child is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed (i.e. wart removal, illness symptoms, etc.). We would charge a well and a sick visit. Many, but not all insurance companies will cover both charges.

➢ Insurance Claims

Insurance is a contract between you and your insurance company. It is your responsibility to determine what benefits and type of coverage your individual or group policy provides. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance. **We are not accepting new patients with Illinois Public Aid and do not accept Public Aid as secondary insurance.** Failure to provide any change of insurance information may result in patient responsibility for the entire bill. It is important for you to respond to your insurance company when information is requested. This will expedite your claims being processed and not delay payment due to missing information.

➢ Auto Accident/MVA

Mundelein Pediatrics will not bill auto insurance or third parties. Payment is due at the time of service. We will provide the paperwork (itemized bill) needed for you to submit to the appropriate auto insurance for reimbursement.

➢ Referrals. Preauthorization's and Lab Testing

- If your insurance company requires a referral and/or preauthorization for any testing or specialist visits, you are responsible for obtaining it from our office. Failure to obtain it may result in a no payment or one that is lower from the insurance company, and the balance will be your responsibility. Receipt of a referral is not a guarantee of payment by your insurance company.

- Please be aware if your insurance company requires you to go to a specific Lab Facility for any lab testing, it is the patient's responsibility to inform your provider.

➢ Fees

- Mundelein Pediatrics requires 24-hour notice for an appointment cancellation. Appointments missed and not previously canceled may be charged a $25.00 fee. New patients, with two (2) No Shows/missed appointments; existing patients, with three (3) No Shows/missed appointments **may** be discharged from the practice. (4) Initial School forms are free if requested at the time of service, subsequent forms will be completed for a $10.00 charge per form effective 06/01/2018.

- The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.
- Patients' requesting copies of medical records will be charged $15.00 per child.
- I further agree and understand that this office can only code and file a claim for my child's visit with the diagnosis that is documented in the medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

➢ **Collections**

- In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections, including any attorney fees. **For accounts in collection, patient visits may be limited to sick only, and if so, you will be directed to our Business Office prior to scheduling an appointment.**
- Accounts with continual past-due balances over 75 days, accounts that have been or are currently in collections, or who have filed for bankruptcy, may be required to keep a current credit or debit card on file. As a courtesy, we will bill insurance first, and send a statement for any balance due after insurance response. If no payment is received within 30 days of the statement date, we will automatically bill the card on file for the balance.

Divorce/Separation/Custody Agreement

Mundelein Pediatrics, S.C. ultimately holds both parents responsible for payment. In the event the account is referred to a collection agency, both parents' names and demographic information will be submitted. A divorce decree is a document that involves you, your ex-spouse/partner and the courts. Although a divorce decree may state that an ex-spouse/partner is responsible for medical bills, Mundelein Pediatrics, S.C. has no authority to enforce compliance or to act as a mediator between the parties.

Please understand that these policies and fees are subject to change, and all changes will be posted in our front desk reception area and on our website. They will become effective at the time they are posted. By signing below, you are consenting to accept and abide by any posted changes as well.

I have read, understand and agree to the financial policy statements listed above and on the previous page. By signing this agreement, I agree to all terms and conditions contained herein and understand that the agreement will be in full-force and effect as of the date signed. I also authorize all insurance benefits to be paid directly to Mundelein Pediatrics, S.C., for services rendered and authorize Mundelein Pediatrics, S.C. to release information to my insurance company when requested.

_____

Name of Responsible Party/Parent, Guardian or Patient (If 18 years or older) (Please Print)

_____

Signature of Responsible Party/Parent, Guardian or Patient (If 18 years or older)

_____

Date Signed