MUNDELEIN PEDIATRICS, SC

Mundelein Pediatrics, S. C.
Pediatrics - Adolescents
1170 E. Belvidere Road • Suite #106
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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 with the following people.

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

Name	Relationship to patient	Phone Number

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.

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 Public Aid and do not accept Illinois 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: Fee Schedule Update

- Mundelein Pediatrics requires 24-hour notice for an appointment cancellation. Any missed appointment will result in a $100 fee charge to your account. Existing patients with three (3) No Shows/missed appointments, **may** be discharged from the practice. Initial School forms are free if requested at the time of service, replacement forms will be completed for a $10 charge per form effective 02/10/2025.

- The charge for a return 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.
- Patient requesting copies of medical records will be charged $25 per child.
- I further agree and understand that this office can only code and file a claim for my child's visit with diagnosis that encountered and documented in the medical record. Thus, to ask this office to change 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 have their visits limited to sick only, and you will be directed to our Business Office prior to scheduling and 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 that 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