Consent to Treat

Patient Name: _____

DOB: _____

Consent from Parents or Guardians for Authorized Persons:

As the legal parent or guardian, I am granting permission for the person(s) listed below to bring my child in for treatment and/or care.

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to:

- **Treatments**
- **Vaccines**
- **Referrals**
- **Medical Records**
- **All medical history pertaining to my child**

_____ **Initials**

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

Parent/Guardian Signature Date

(Valid for 1 calendar year, must be updated every year)

Financial and Office Policy

Thank you for choosing Desert Valley Pediatrics (DVP) for the care of your child. This Financial and Office 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 DVP policies.

Self-Pay Patients: If you have no insurance coverage, full payment is expected at the time of service. Please contact an office staff member for fees.

Commercial Insurance: As a courtesy, DVP 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. Knowing and understanding your insurance benefits is your responsibility. If you have any "Out of Network Benefits" with a plan we are not contracted with, we will bill your insurance as a courtesy. Any patient responsibility will be billed to the guarantor on file. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to notify DVP if there is a change to your insurance coverage, residence or phone number. Ultimately, it is up to you to know your insurance benefits.

Lateness: If you are late for your appointment time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled to another day or work you in behind other scheduled appointments.

No Shows/Cancellations: A no showed appointment or an appointment cancelled less than 6 hrs. before the visit time leaves an open appointment that could have been used by a patient in need of medical care. If three (3) occurrences of a no show or short-notice cancellation (6 hrs. or less) happen during a rolling 6-month period, the family will be dismissed from the practice and unable to receive further treatment at DVP. Generally, on a 2nd occurrence, we will make an attempt to call and counsel you on the policy. Appointments can be cancelled by text or call to our office directly or by using our patient portal.

Appointments: Walk-in and sibling add-on appointments are not accepted. We want to take care of your child's illness; however, it is unfair to ask our patients who have a scheduled appointment to wait while someone without a pre-scheduled appointment is seen. If you feel that your child cannot wait to be seen, ask to speak to a triage nurse for evaluation and they will make a recommendation.

Visits: The provider is required to code the visit based on all care provided and if a preexisting problem is addressed in the process of performing a Well Child Check and the problem is significant enough to require additional work (either during the visit or after), additional billing for the problem visit may occur. With this in mind, while the appointment may have been scheduled for a Well Child Check or just for a problem(s), if both types of services are provided during the exam then both types of services may be billed.

Laboratory Fees: You will receive a separate laboratory fee for outside lab services. Any lab services that are not covered by your insurance will be your responsibility. It is your responsibility to go to a contracted lab. Desert Valley Pediatrics is not affiliated with any labs.

Circumcisions: Circumcisions are elective and some insurances do NOT cover this procedure. Full payment is due at the time of service if it is not a covered benefit.

Return Check Fees: There is a $35 fee for any checks returned by the bank. Non-Sufficient Funds checks must be paid in full with certified funds (money order, certified check, or cash). You will no longer be able to make payments on your account with a check. Instead, future payments will need to be cash, credit card or money order only.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt from you. You will receive several statements with letters and a final phone call in an attempt to collect. If we have to refer your account to a collection agency, there will be at $25 surcharge fee imposed on your account and you agree to pay all of the collection costs which are incurred.

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 the child in for medical treatment responsible for payment at time of service.

Privacy Consent: We are concerned with protecting your privacy. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

By signing the form provided, you consent to our use and disclosure of protected health information about your child for treatment, payment, and healthcare operations as described in our Notice. The Practice may condition receipt of treatment on this consent.

You have the right to request, in writing, that we restrict disclosure of health information about your child. We are not required to agree to this restriction but if we do, we will honor our agreement.

By signing this acknowledgement, you agree to DVP's Privacy Policy as well as acknowledge the receipt of the Health Current's Notice of Health Information practices.

You understand that this consent will remain in force from the time forward and that it may be revoked by providing written notice.

I have read and understand DVP's Financial and Office Polices 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 DVP. 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 and DOB: _____

Responsible Party Name (Please Print): _____

Your signature: _____ Date: _____