CONSENT FOR SERVICES

Patient Name_____ Date of Birth_____

AUTHORIZATION FOR TREATMENT:

I authorize Joy & Crown Pediatric Specialists to provide treatment to myself or the above named patient.

ASSIGNMENT OF BENEFITS:

I authorize my insurance company to assign directly to Joy & Crown Pediatric Specialists all benefits otherwise payable to me for services rendered.

BILLING TO SECONDARY INSURANCE:

As a courtesy to their patients and at the sole discretion of Joy & Crown Pediatric Specialists, Joy & Crown's billing department may submit any outstanding balances not covered by primary insurance to a patient's secondary insurance carrier. HOWEVER, this policy applies only to in-network insurance, and Joy & Crown *cannot* submit claims to insurance carriers with whom Joy & Crown has no contract. For example, Joy & Crown Pediatric Specialists is neither able nor obligated to submit outstanding balances to any form of Medicaid, regardless of whether Medicaid is a patient's primary or secondary insurance. I understand that, if my secondary insurance is out of network with Joy & Crown, balances not covered by primary insurance automatically become patient responsibility. I further understand that, if I have any concerns regarding this policy, I can speak with Joy & Crown's front office staff regarding self-pay policies and options.

REFERENCE LABORATORY SERVICES:

I understand that Joy & Crown Pediatric Specialists utilizes the services of an outside lab to perform some tests. I further understand that the Reference Laboratory will bill separately for its services. I authorize Joy & Crown Pediatric Specialists to provide demographic information as necessary for billing purposes.

CANCELLATION OF APPOINTMENTS:

I understand that, in order to avoid my absence being archived as a "no-show," I must make every effort to let the office know that I am cancelling an appointment at least 24 hours prior to the scheduled appointment day/time. I further understand that future services may be denied if I engage in a consistent pattern of "no-shows."

NON VIOLENCE POLICY:

I understand that Joy & Crown Pediatric Specialists is committed to providing its employees with a safe, nonviolent workplace and reserves the right to determine whether particular conduct violates this policy or is otherwise inappropriate.

USE OF DISCLOSED PROTECTED HEALTH INFORMATION:

●My insurer may share my past, current, and future health and account records with Joy & Crown Pediatric Specialists about services I've received from Joy & Crown Pediatric Specialists and other care providers unrelated to Joy & Crown Pediatric Specialists. These records may be used by Joy & Crown Pediatric Specialists as needed in the management and coordination of my care and also in the improvement of the quality of that care. If I do not agree to this, I will initial in the space provided below:

●_____My insurer MAY NOT RELEASE any of my identifiable health records from providers unrelated to Joy & Crown Pediatric Specialists for the purposes described above.

PAYMENT AGREEMENT/COLLECTION POLICY:

I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered or to be rendered by Joy & Crown Pediatric Specialists. I understand that it is my responsibility to provide Joy & Crown Pediatric Specialists with current insurance information. I understand that a finance charge of 8 % per annum is charged to any balance 60 days or older on my account. I will be responsible for the balance due, plus any costs that are incurred by Joy & Crown Pediatric Specialists in collecting an outstanding balance.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

Signature:_____ Date:_____

(Patient if 18+ yrs old or Parent / Legal Guardian)

Relationship to Patient if signing on his/her behalf:_____