**Welcome Letter**

Dear New Patient,

We want to welcome you to Pediatric Associates of Northern Colorado. We would like to thank our referral sources. If you would please take a moment to complete this form and return it to the front desk.

We look forward to helping you and your family with your medical needs.

Thank you,

Pediatric Associates of Northern Colorado

Please check all that apply: Today’s Date:\_\_\_\_\_\_\_\_

* A Physician/Provider (Please Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Friend or Family / Word of Mouth: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Insurance Company
* Siblings are established patients
* Google Search / Reviews
* Yelp Search / Reviews
* Online Advertisement
* Outdoor Advertisement
* Facebook
* Website
* Lincoln Center Playbill Advertising
* Fossil Lake Living Magazine Advertising
* Drive By/Location
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of Notice of the Privacy Practices of PANC**

I acknowledge that I have received or given the opportunity to receive a copy of the Notice of Privacy Practices for PANC. This notice describes how PANC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. Pediatric Associates reserves the right to modify the practices outlined above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_

Printed Name Relationship to Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**HIPAA Guidelines**

Due to HIPAA regulations our office requires written consent from a parent or legal guardian to see and/or treat children under the age of 18, when coming to the office by themselves. This also applies to a patient brought in by a grandparent or friend. Once a patient turns 18, new patient intake sheets are filled out and signed by the patient. HIPAA guidelines mandate we must have the patient’s consent to release their medical information, even to a parent.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(printed name and relationship to patient)

hereby grant permission for

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (printed name and relationship to patient)

to seek medical treatment for my above-named child, at Pediatric Associates of Northern Colorado. This authorization includes, but is not limited to, treatments and procedures prescribed by the health care provider, and prescription medications. I understand I will be responsible for all costs associated with these services. This authorization is good for the following time period: Beginning Date: \_\_\_\_\_\_\_\_\_\_\_ Ending Date: \_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship to Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Consent to Treat**

I give my permission for Pediatric Associates of Northern Colorado to treat my child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, according to the standards of care defined by the American Association of Pediatrics (AAP) and of medical necessity as deemed appropriate by the treating provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship to Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Financial Policy**

**Insurance**

Please be aware that your insurance contract is between you and your carrier. We will bill your insurance as a courtesy.

It is your responsibility:

* Verify that our office is a “in-network provider”
* Verify eligibility and benefits per your specific plan
* **Provide insurance card at each visit**
* All charges are patient responsibility until account is paid in full

**Invoicing/Payments**

After we have submitted claim to insurance, we will send you an itemized statement. Payment is due upon the receipt of the first statement. If you have questions or need to set-up payment arrangements please call our billing office Monday-Friday 8:00-3:00pm. Delinquent accounts (over 90 days past due), will be sent to collections. **NOTE: If your account goes to collections you will be dismissed from the practice. We will only be available for emergent care for 30 days, until you establish care with another physician.**

**Payment at Time of Service**

Our office requires payment for the office visit or co-pay be paid at the time of the visit. If we have to bill you for your co-pay there will be an additional $10.00 billing service charge.

**After Hours Services and Phone Calls**

There will be a $10.00 charge for calls made to the doctors after regular office hours. The after-hours phone call fee will not be charged if the patient is seen within 48 hours, seen in urgent care, or ER for the same issue.

**Unscheduled Visits**

We do have an unscheduled visit charge of $15.00 in addition to your visit charges. This charge also applies to a sibling being treated without a scheduled visit.

**Appointment Confirmations, No Shows and Late Arrivals**

We ask that you arrive 10 minutes prior to your appointment time.
Our office requires a 24 hour notice for cancellation of any well care. Failure to cancel prior to 24 hours before the visit will result in a $50.00 cancellation fee.
For all other appointment types; failure to cancel prior to 1 hour before your visit time will result in a $25.00 late cancellation fee.
The above noted fees will NOT be billed to your insurance; they are your personal responsibility.

If an appointment is missed 3 times you will be asked to transfer care to another practice.

**Financial Policy**

**Medical Records**

We prefer to deliver Medical Records electronically. If a printed version of your records is necessary a $25 fee is assessed.

**Returned Checks**

A $25.00 service charge is added for all returned checks.

**Rush Form Fee**

A $20.00 rush fee is charged to complete a form the same day.

**By signing this form I acknowledge that I have read, understood, and agree to the above financial policy set forth by *Pediatric Associates of Northern Colorado*.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship to Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Office Policy**

**Mission Statement**

To serve our patient in a courteous, professional, competent and kind manner. We want to let our patient know they are valued and we strive to develop long term relationships with our patients and their families. We promote healthy lifestyles and injury prevention so that our patients may enjoy a lifetime of good health.

**After Hours Services and Phone Calls**

Our office offers after-hour phone services in case of an emergency. Call 970.484.4871, and the on-call provider will be paged. The provider will then call you to determine the next step (treating by phone, referral to urgent care, ER etc.). There will be a $10.00 charge for calls made to the doctors after regular office hours. This charge covers the time taken by the physician to return your call, the dictation of the call for the chart, pharmacy calls if needed, any follow-up procedures that are required of the nurse or any other staff member on the next working day. The after-hours phone call fee will not be charged if the patient is seen within 48 hours of your call Our phone system requires you to leave detailed specific information. Please speak slowly and clearly. Please leave your childs first and last name, date of birth, call back number, and the reason for the call.

**Nurses Voice Mail**

Our triage nurse has a voice mail and messages can be left for them throughout the day. They receive a large number of calls every day, so please be patient when waiting for a return call. If the situation is critical or if you need an appointment, please inform the receptionist so that it can be addressed immediately. The nurses not only receive calls with questions from patients and parents, but calls from labs, other offices and pharmacies for refills. When leaving a message for the nurse please speak clearly and be sure to leave your phone number, date of birth, and name. Please spell the child’s first, last name and date of birth. If you are calling regarding results for tests not performed in our office, please leave the child’s name, date of test and the lab or facility where it was performed at so that the nurses can have all of the information readily available when returning your call. Please be aware it may take 72 hrs for forms to be filled out.

**Medication Refills**

For routine medication refills, please contact your pharmacy first. They will contact us directly for refill requests. When leaving a message for medication refills, the nurses need the name of the child (with spelling), the prescription medicine and the name of the pharmacy we should call. Prescription refills will be called in Monday – Thursday 8:30am-4:30pm and Friday from 8:30am-11:30am. If an ADHD medication refill is needed, a 48-72 hour advance notice is needed. You can call and leave a message on the nurse’s voice mail. The prescription may be picked up from the office in 2-3 days or if a self-addressed, stamped envelope is provided, the prescription can be mailed to you. Medication rechecks visits are performed every 6 months for ADHD, anxiety or

**Office Policy**

depression, and asthma. Yearly well care visits are recommended and this fulfills a medication recheck visit.

**Daycare, Camp, School, Sports Forms and Immunization Records**

Forms that need to be filled out by a nurse can be left at our office for completion and then picked up in 2-3 days. If a self-addressed, stamped envelope is provided we will mail the form to you or the facility. Some forms can also be faxed or emailed to the facility. Parents — please read the requirements for physicals on camp and sports forms. Some forms specify that the child have a physical exam every 12 months. If you need a form filled out, and it indicates the need for a physical exam within the last year, we cannot sign the form unless your child has had a complete physical exam within that time period. Note: If you need a form filled out the same day, we are happy to accommodate, but there will be a $20 rush fee. Simply bring the form to our office, with your payment, let us know it is a rush form, and we will get it done by the end of the business day.

**Well Care Physicals and Sick Appointments**

Well Care Physicals consist of a complete physical exam. Depending on the age of the child, we may check for anemia and perform a autism and developmental screen. Diet and sleep patterns are discussed, as well as in-depth discussions regarding safety and behavioral issues. With adolescent physicals, there may be discussions regarding high-risk behavior, sexuality, peer pressure, school related issues and depression. Additional screenings performed for teens include anemia, cholesterol and depression screenings. A Well Care Physical is required every 12 months for most day care facilities, camps, and junior high and high school sports. The AAP recommends yearly Well Care Physicals from age 2 yrs – 21 yrs. Visits are more frequent under the age of 2 yrs.
Sick Appointments are given a 15-minute time slot (much less than physicals). This time is set for the doctor to examine the patient and diagnose the illness. If your child has multiple symptoms, problems, or concerns, please let the receptionist know when you make the appointment so the visit can be extended. We want to make sure the doctor has enough time to address all of your concerns without feeling rushed.

**Unscheduled Visits**

Our schedule is not set for walk-in appointments. Please call ahead to establish an appointment time. We do have an unscheduled visit charge of $15.00 in addition to your co-pay. If you have an appointment for one child and bring a sibling in and want that child to also be seen at the same time without notifying the office beforehand, there will be an unscheduled visit charge in addition to the co-pay for each child.

**Office Policy**

**Appointment Confirmations, No Shows and Late Arrivals**

Over the past few years we have had a dramatic increase in the number of patients who no-show for appointments, are late for their appointments, or call to reschedule without an appropriate notice. Not showing up for an appointment prevents us from scheduling other patients. Being late for an office visit causes the provider to fall behind in his or her schedule and delays the visit for other patients who arrive on time. In consideration of our other patients, a client who is late may be asked to reschedule their appointment.

Additionally, a missed appointment charge will be incurred. We ask that you arrive 10 minutes prior to your appointment time.
Our office requires a 24 hour notice for cancellation of any well care or medication appointment. Failure to cancel prior to 24 hours before the visit will result in a $50.00 cancellation fee.
In addition we require a 1 hour notice of cancellation or rescheduling for ALL other appointments (sick visits, nurse appointments, vaccine administration appointments, weight checks, etc.). Failure to cancel prior to 1 hour before your visit time will result in a $25.00 late cancellation fee for sick visits and a $10.00 fee for nurse visits, weight checks, and vaccine administration visits.
The above noted fees will NOT be billed to your insurance; they are your personal responsibility. Our office sends out a courtesy reminder prior to your appointment; it is very important to make sure that your phone number is up to date to receive those reminders. It is your responsibility to remember your appointment. If an appointment is missed 3 times you will be asked to transfer care to another practice.
Please call 970.484.4871 to cancel or reschedule an appointment.

**Referrals**

Many insurance companies require a referral from your primary care physician before a specialist may see you. Many times we can treat the problem, thus saving you additional time. Once you have been referred to a specialist by our office call your insurance to see if they are in-network and if a referral is needed, call that specialist, set up an appointment time, and then call us promptly with that date and the specialist’s name. It is important that this sequence be kept.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship to Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date