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Authorizations and Policies

Consent for Treatment

I hereby authorize Grow With Me Pediatrics LLC to provide the necessary care, treatments, and interventions discussed with my provider for my child. I authorize Grow With Me Pediatrics LLC to consult with other medical providers as necessary for my child's health, which has been described to me in detail in their privacy policy. I have obtained and read the Grow With Me Pediatrics Privacy Policy which discloses how my child's medical information is protected and utilized. I authorize the use and disclosure of my child's healthcare information for treatment, consultation, billing, and appropriate medical interventions. Grow With Me Pediatrics LLC is allowed to contact my email and or phone number for appointment reminders, insurance questions or issues, lab or test results, and discussion about my child's care.

Initial: _____

Financial Policy & Assignment of Benefits

I authorize Grow With Me Pediatrics LLC to bill my insurance carrier which I have properly provided prior to my visit. I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand that services provided which are not covered by my insurance carrier are ultimately my financial responsibility. I am responsible for my deductible. All co-pays must be paid at time of visit. My insurance company will make payments directly to Grow With Me Pediatrics LLC through their EHR company, Athena. Any questions that I may have regarding what my insurance covers, I am responsible for contacting them and understanding my financial benefits. I am responsible to notify Grow With Me Pediatrics LLC of any insurance carrier changes.

Initial: _____

Release of Billing Information

I authorize Grow With Me Pediatrics LLC to disclose and release to my insurance carrier(s), including Medicaid and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

Initial: _____

Vaccine Policy

Grow With Me Pediatrics LLC values shared decision making and therefore will work with families who wish to pursue a delayed vaccination schedule. However, we strive to provide optimal care for our patients and therefore we strongly value childhood vaccinations. All children must have an established vaccination schedule in place that is authorized by the provider. Children must have initiated vaccinations by two years of age, or will be terminated from the practice. We do not exempt any children from any of the routine childhood vaccinations and do not allow for unvaccinated patients in our practice. We follow the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

I understand that if my child is a patient of Grow With Me Pediatrics, they must be vaccinated.

Initial: _____

Late, Cancellation, & No Show Policy

We understand, especially as mothers ourselves, that life is busy and schedules are difficult. However, we want to be able to provide the best care for our patients, so we value our time, just like we value yours. Any patient that is more than fifteen minutes late to an appointment will be kindly asked to reschedule by our staff. For those appointments that are no showed, the first time is excusable. The second no showed appointment is scheduled to a \$50 no show fee. Any no showed visits after that are subject to evaluation by the owner. We kindly request that any physicals in which a parent requests to cancel, a 24 hour notice is provided. Any sick visit that is cancelled, we require at least a 2 hour notice. Appointments that are not cancelled in a timely manner may be subject to our no show policy.

Initial: _____

Assessment of Puberty

Grow With Me Pediatrics follows the standard of care for well child exams, which includes an assessment of sexual maturation. It is important to assess for the absence of premature puberty or any physical abnormalities. This entails a proper physical examination that requires a visual assessment with a chaperone present. If you are uncomfortable with this assessment or have any questions, please consult with your provider. If you wish to decline this assessment, please let your provider know during your exam. Some physicals, such as a sports physical, require these assessments to assess for hernias.

Initial: _____

Medication Refill Policy

We kindly request that for all ongoing medications, you first contact your pharmacy for refills. We then receive these requests through our EMR. If you are having difficulties with this, please contact our office staff. For any controlled substance, we have 24 business hours to refill all medications. Your child must be up to date on their medication follow-up appointments for refills to be granted.

Initial: _____

Divorced or Separated Parents

We understand that every family's structure is different, however, it is your responsibility to communicate if needed regarding your child's care or visit. Whoever is present for the visit is responsible for communicating the result of that appointment to the child's other legal guardian or parent if deemed necessary. Providers are not responsible for contacting any non-present parent or guardians at time of visit. The parent present for the visit is responsible for the co-pay. Our staff will not be placed in the middle of domestic disagreements or disputes.

Initial: _____

Signature: _____

Date: _____

