SMALL WORLD PEDIATRICS LLC
332 S ORCHARD SPRINGS DR #150
PUEBLO WEST, CO 81007
719-253-7640

CONTACT CONSENT

I give consent to Small World Pediatrics to contact me through the following methods:

_____ ***Phone Call*** _____ ***Text*** _____ ***Email***

MEDICATION HISTORY CONSENT

I give consent to Small World Pediatrics to access my child's medication history electronically. _____ ***INITIAL***

FINANCIAL POLICY

We strive to give you the best service possible with the limitations placed on us by federal/state regulations and your insurance company. As you expect us to be responsible in the care we provide you, we expect you to be responsible in the payment of your bill. The financial relationship is between you and Small World Pediatrics. You have a contract with your insurance company to assume some or all of that responsibility. This does not relieve you of your responsibility for your bill if your insurance company is not reliable in paying on your behalf.

A current copy of your insurance card and any co-pays or deductibles are due at the time of service. You will be asked to reschedule without them.

Even through we have a contract with your insurer, their failure to pay does not relieve you of any financial responsibility.

We consider the billing of your insurance a courtesy to you, not a substitution of financial responsibility for your bill. If your insurance fails to pay correctly according to contract or to the recognized CPT coding guidelines, we will appeal your claim to them one time. With continued refusal to pay, you will be required to pay us directly and then you may file a complaint with the Colorado Insurance Commissioner for assistance in dealing with your insurance carrier.

It is your responsibility to understand the details of your insurance coverage: if your coverage is effective; if the providers are in your provider network; to know whether or not you have a copay, and how much; and whether or not your have a deductible, and if it has been met.

After correct insurance claim processing, any other amounts owed by you as specified by the explanation of benefits from your insurance will be billed to you. We expect and appreciate prompt payment upon receipt. A fee will be assessed to cover any costs incurred due to returned checks.

Appointment cancellations: Due to limited times available for visits with our doctors and the importance of close follow-up for many medical conditions, appointments MUST be cancelled/rescheduled at least 24 hours in advance. If you are unable to attend your appointment and do not allow 24-hour notice, a missed appointment fee may be assessed or you may be discharged from our practice.

If you fail to pay what you owe for the services we provide, we will be unable to continue providing your medical care, and your account will ultimately be turned over to a collection agency. You will be responsible for any additional legal and collection fees accrued.

If you have any questions about these policies, or wish to make other arrangements to pay your bill, please ask to speak to our billing manager. _____ ***INITIAL***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's *Notice of Privacy Practices*. _____ ***INITIAL***

PATIENT NAME:_____ **DOB:**_____

GUARDIAN SIGNATURE:_____ **DATE:**_____