larchmont pediatrics
pediatric and adolescent medicine

Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White / Other

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White / Other

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White / Other

Child 4: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White/ Other

Address:

_____

(Street) *(City)* *(State & Zip)*

321 north larchmont blvd, suite 1020, los angeles, ca 90004
phone (323) 960-8500 fax (323) 960-8585

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

*Relationship to patient:*_____ *Effective Date:*_____

Insurance Carrier: _____

ID# _____ *Group #* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

*Relationship to patient:*_____ *Effective Date:*_____

Insurance Carrier: _____

ID# _____ *Group #* _____

Parent/Legal Guardian 1:

Name: _____

Relation to Patient:_____

Lives with patient? Yes / *No*

If you do not live with the patient, please provide the address:

_____

(Street) *(City)* *(State & Zip)*

Date of Birth: ____ / ____ / ____ *Social Security #:* _____ - _____ - _____

Home Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Work Phone: (____) _____ - _____ *Email:* _____

Employer: _____ *Occupation:*_____

How would you ideally prefer to be contacted? Please circle one:

Home Phone Work Phone Cell Phone

Larchmont Pediatrics may leave messages on all my phone contacts listed above.

Circle one: Yes No Initials_____

Parent/Legal Guardian 2

Name: _____

Relation to Patient: _____ *Lives with patient?* Yes / No

If you do not live with the patient, please provide the address:

_____

(Street) *(City)* *(State & Zip)*

Date of Birth: ____ / ____ / ____ *Social Security #:* _____- _____ - _____

Home Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Work Phone: (____) _____ - _____ *Email:* _____

Employer: _____

Occupation: _____

How would you ideally prefer to be contacted? Please circle one:

Home Phone Work Phone Cell Phone

Larchmont Pediatrics may leave messages on all my phone contacts listed above.

Circle one: Yes No Initials_____

Child's parents are: Married___ Divorced___ Never Married ___ Separated___

Widow(er)___ other____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? Yes / No

_____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents:

Name & Relationship

1: _____ *Phone*: (_____) _____ - _____

2: _____ *Phone*: (_____) _____ - _____

Consent to Treat:

I hereby give consent to Larchmont Pediatrics to perform any x-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where the treatment is provided. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Larchmont Pediatrics recommends.

I voluntarily authorize and consent to the exchange of medical data including medications, consults, vaccinations, diagnostic tests, and hospital records with other providers who have provided care or may provide care in the future.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed:_____

Dated:_____

Print Name:

_____

Please specify relationship to minor:

( ) parent with legal custody

( ) guardian with legal custody

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TRANSFER AND CORRESPONDENCE OF YOUR CHILD'S
HEALTH CARE INFORMATION VIA EMAIL

We are happy to respond to your request, but in order for us to do so via email you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your request. Please note the physician is unavailable via email and no medical advice will be given over email.

REQUEST CONSENT FORM

I, _____, authorize Larchmont Pediatrics and any of its employees to send information that I request to my email address provided below. I am aware the physician is unavailable via email and no medical advice will be given over email. This consent form will be effective until I notify Larchmont Pediatrics to revoke it in writing.

Your name: _____ Relationship to child: _____
Child's name: _____
Email address:_____
Signature:_____ Date: _____

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Family Plan for Non-Covered Services

At Larchmont Pediatrics, we are committed to providing the best possible care to our patients. Many changes have taken place in the health insurance industry in recent years. Services once covered in full are now partially covered with lower reimbursements, covered only under certain circumstances, or in some cases not covered at all.

We want to provide high quality medical care that is based on our families' needs but unfortunately this means providing services that are not covered by insurance companies. We have decided to charge an annual fee to all our families in order that we may provide comprehensive, exceptional care. This fee includes non-covered and non-reimbursable services such as:

- On call service with access to a physician 24 hours a day, 7 days a week. We do not use an answering service, your phone call will be directed to the physicians cell phone. This will minimize unnecessary trips to the emergency department or urgent care centers and can save you hundreds of dollars.
- This allows us to limit the size of our practice, therefore lessening patients wait time to see the physician.
- Completing forms for child care centers, schools, sports and camps within 3 days.
- Access to our web-based secure patient portal system, including access to your child's immunization record and summaries of their visits.
- Access to CHADIS, a website where you can fill out online questionnaires prior to your visit including screenings for autism.
- Access to the AAP Education Library through our website.
- Ability to e-mail our office staff for appointment requests, for questions about insurance and billing, to send in school and camp forms and have us send them back to you, and to request a callback from the doctor (note: no medical advice will be given by e-mail for privacy reasons and the doctor will not be able to e-mail you directly).
- Providing "same day" sick appointments.
- Calling in new and refilling old prescriptions when appropriate.
- Documenting with an electronic health record system that is designed specifically for the practice of pediatrics.
- Coordinating care with other pediatric specialists and therapists
- Conducting patient visits by only board-certified (or board-eligible) pediatricians.
- Submitting insurance claims on behalf of all patients that are out-of-network.
- Sending copies of medical records to specialists and/or other providers at your written request.

The Family Plan applies to all families at Larchmont Pediatrics. The fees are as follows:

Families with one child: $150 per year
Families with two children: $200 per year
Families with three or more children: $250 per year

Please feel free to contact our office manager, Diane Hall, at (323) 960-8500 or by e-mail at dianehall@larchmontpediatric.com with any questions or concerns. We are aware that health insurance is expensive. By charging a single annual fee and not charging you for individual services (ie each telephone call or e-mail, a "same day" appointment surcharge, access to the portal, etc) your out of pocket expenses will actually be lower. However, if you are experiencing financial hardship, we will work with you so that you can remain in our practice.

Our goal is to provide comprehensive, high quality medical care to your family. We are honored to be your family's medical home!

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Larchmont Pediatrics Family Plan Agreement

I agree to Larchmont Pediatrics family plan administrative fee. I understand that this fee is for items and services not covered and not reimbursed by my insurance plan.
The cost of the annual administrative fee is:

- Families with 1 child: $150.00 per year
- Families with 2 children: $200.00 per year
- Families with 3 or more children: $250.00 per year

This fee will be paid in full within 30 days of your first visit and thereafter annually.
Please list your child/children below.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Childs's Name: _____ Date of Birth: _____

Enclosed is my payment of $_____

Print Name: _____

Signature: _____ Date: _____

Please return entire form with your payment.

If you choose to decline, Larchmont Pediatrics will forward a copy of your medical records to your new pediatrician with your written request. If you should change your mind in the future you will always be welcomed back.

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Office Policies

We would like to thank you for choosing Larchmont Pediatrics. Our goal is to provide and maintain a good physician-patient relationship. To achieve this, we would like to keep you informed of our current office and financial policies as outlined below. Your clear understanding of these policies is important to our professional relationship.

Financial Policies

We will bill your insurance company after each visit. It is your responsibility to provide us with current insurance information. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co pays must be paid at the time of service. After your visit charges have been reconciled with your insurance, you will receive a billing statement from our office. Any balance remaining on your account for services not covered by your insurance company is your responsibility. If you have no insurance, payment for an office visit is to be paid in full at the time of service. The amount on your statement will reflect your balance, and that balance is payable on receipt. A $30 fee will be charge for any return checks. A $25 late fee will be automatically added to your bill for every 30 days your payment is late. Any balance outstanding longer than 90 days will be forwarded to a collection agency. It is your responsibility to understand your insurance policy and what benefits are covered and not covered including for well check-ups. As a courtesy we will bill your insurance for you. However, all charges not covered by your insurance company are your responsibility. Please be sure to notify us of any changes in insurance, address or phone numbers.

Remember, newborns must be added to your insurance plan within the first 30 days after birth. Larchmont Pediatrics Annual Family Fee will be due each year. For detailed information please see our Family Plan Agreement or visit our website at www.larchmontpediatric.com. You can reach our billing department M-F from 9:00am-5:00pm at (323) 960-8500 or at billing@larchmontpediactric.com.

Appointments

In order to see our patients on time, we encourage our patients to arrive 15 minutes prior to the schedule appointment time. Patients who arrive more that 15 minutes late will be rescheduled. In order to receive your preferred date and time for your well-child visits, we ask that you schedule your appointments 6 to12 weeks in advance. All appointments must be scheduled including sick visits. Sick visits can be booked and seen on the same day. If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow us time to provide that time slot to another patient. Failure to appear for an appointment or canceling less than 24 hours prior to a scheduled appointment will result in a $50 charge.

Forms and Prescription Refills

If you need a school or camp form filled out please give us a minimum of 3 days to complete and return them. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Vaccine Policy

We feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. If you should absolutely refuse to vaccinate your child despite all our efforts, we will respect your decision but we will ask you to find another health care provider who shares your views. Please feel free to discuss any concerns you may have about vaccines with us. We welcome having the conversation with you. You may see our philosophy on vaccines on our website www.larchmontpediatric.com.

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NOTICE OF PRIVACY PRACTICES

Effective Date: April 2, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your child(ren)'s medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to your child(ren) as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your child(ren)'s medical information. It also describes your rights and our legal obligations with respect to your child(ren)'s medical information. If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this notice.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about your child(ren) to provide their medical care. We disclose medical information to our employees and others who are involved in providing the care your child(ren) need. For example, we may share your child(ren)'s medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to your child(ren), or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help your child when he/she is sick or injured.

Payment: We use and disclose medical information about your child(ren) to obtain payment for the services we provide. For example, we give your child(ren)'s health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to your child(ren).

Health Care Operations: We may use and disclose medical information about your child(ren) to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your child(ren)'s medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it

except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you or your child(ren), when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

Appointment Reminders: We may use and disclose medical information to contact and remind you about your child(ren)'s appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in sheet: We may use and disclose medical information about your child(ren) by having you sign in when you arrive at our office. We may also call out your child(ren)'s name when we are ready to see you.

Notification and communication with family: We may disclose your child(ren)'s health information to notify or assist in notifying a family member, your child(ren)'s personal representative or another person responsible for their care about your child's location, his/her general condition or in the event of your child's death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your child(ren)'s care or helps pay for their care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing: We may contact you to give you information about products or services related to your child(ren)'s treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to your child(ren), or to provide your child(ren) with small gifts. We may also encourage you to purchase a product or service when we see you. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization.

Required by law: As required by law, we will use and disclose your child(ren)'s health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health: We may, and are sometimes required by law to disclose your child(ren)'s health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health oversight activities: We may, and are sometimes required by law to disclose your child(ren)'s health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and administrative proceedings: We may, and are sometimes required by law, to disclose your child(ren)'s health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about your child(ren) in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law enforcement: We may, and are sometimes required by law, to disclose your child(ren)'s health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners: We may, and are often required by law, to disclose your child(ren)'s health information to coroners in connection with their investigations of deaths.

Organ or tissue donation: We may disclose your child(ren)'s health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public safety: We may, and are sometimes required by law, to disclose your child(ren)'s health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized government functions: We may disclose your child(ren)'s health information for military or national security purposes or to correctional institutions or law enforcement officers that have your child in their lawful custody.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your child(ren)'s health information/record will become the property of the new owner, although you will maintain the right to request that copies of your child(ren)'s health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Larchmont Pediatrics, Inc. will not use or disclose health information which identifies your child(ren) without your written authorization. If you do authorize this medical practice to use or disclose your child(ren)'s health information for another purpose, you may revoke your authorization in writing at any time.

C. Patient Rights

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your child(ren)'s health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your child(ren)'s health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your child(ren)'s health information, with limited exceptions. To access your child(ren)'s medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Right to Amend or Supplement: You have a right to request that we amend your child(ren)'s health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your child(ren)'s health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your child(ren)'s health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to Alternative Communication: You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at end of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website at www.larchmontpediatric.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how Larchmont Pediatrics, Inc. handles your health information should be directed to our Privacy Officer listed at the end of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Privacy Officer: Diane Hall
Telephone: (323) 960-8500 Fax: (323) 960-8585
E-mail: dianehall@larchmontpediatric.com
Address: Larchmont Pediatrics, Inc. 321 N Larchmont Blvd, Suite 1020, Los Angeles, CA 90004

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Acknowledgement and Assignment of Benefits

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the Notice of Privacy Practices which describes how medical information about my child (ren) may be used and disclosed, and how I can get access to this information. To remain environmentally friendly, I understand that this information is available online at www.larchmontpediatric.com and a printed copy will be provided at my request.

Initials_____

FINANCIAL & OFFICE POLICIES

I hereby acknowledge that I have read and I understand Larchmont Pediatrics, Inc's financial and office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Initials_____

ASSIGNMENT OF BENEFITS

I hereby authorize all insurance benefits to be paid directly to Larchmont Pediatrics, Inc. for services rendered. I understand that I am responsible for charges as designated by my insurance company (e.g. deductibles, coinsurance, and co-pays). I am also responsible for charges not covered by insurance including but not limited to the annual family fee, charges for missed appointments or finance fees accrued on late balances. I authorize Larchmont Pediatrics, Inc. to release information to my insurance company when requested.

Initials_____

Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to Larchmont Pediatrics, Inc.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Please Print Name Relationship to Patient

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Good health care for newborns, infants, children, and adolescents begins with the well-child visit (checkup) and other services that help keep children healthy. These are *preventive* services. Our doctors and staff provide these services based on a plan called Bright Futures. The American Academy of Pediatrics (AAP) made this plan to help doctors and families know what preventive services children should receive from birth to 21 years of age, such as screening tests, and advise about staying healthy and safe. This plan can be altered to suit each child as needed. We also follow the AAP vaccine schedule for newborns, infants, children, and adolescents.

Because preventive services are important to keeping children healthy, the Patient Protection and Affordable Care Act (health care reform law) includes a rule that all preventive care screenings and services included in the Bright Futures plan and vaccine schedule must be covered by ***most*** health plans. This is not always true, though, as some older plans, called grandfathered plans, do not have to pay in full for preventive services.

Health Plan Terms to Know
Co-payment: A fixed amount that you pay for certain health services before the health plan pays
Coinsurance: The portion of the charge that is not paid by the health plan (usually a fixed percent of each amount paid by the plan)
Deductible: An amount that must be paid before the health plan pays for covered services

There may also be times when a child needs a service that is not considered preventive on the same day as a well-child visit. If a child is not well or a problem is found or needs to be addressed during the checkup, the physician may need to provide an additional office visit service (called a *sick visit)* to care for the child. This is a different service and is billed to your health plan in addition to the preventive services provided on that day. If you have a co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.

We value your time and want to make the most of each appointment for the child. This is why we will address any problem that needs a doctor's care during well-child visits so that only one trip is needed. Some services that may be provided and billed in addition to preventive services include

The doctor's work to address more than a minor problem, which will be billed as an office visit (eg, if the doctor gives a prescription, orders tests, or changes care for a known problem)

Medical treatments (eg, breathing treatments)

Any surgery (eg, removing splinters or something the child put in his or her nose or ear)

Tests performed in the office that are not included in the Bright Futures plan

Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services provided. Please feel free to ask questions about services that may not be paid in full by your health plan on the day of your visit. It is our pleasure to help.

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