Patient Consent for Treatment, Payment and Healthcare Operations
Four Seasons Pediatrics

We are a Patient Centered Medical Home. Patient Centered Medical Homes (PCMH) are about what patients want: a focus on patients themselves and their health care needs. Medical Homes are the foundation for a health care system that gives more value by achieving the "Triple Aim" of better quality, experience and cost. Four Seasons Pediatrics embodies the spirit and practice of the Patient Centered Medical Home. Everyone in the practice – from clinicians to front desk staff – works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions.

- We will deliver safe, effective and efficient care that is well coordinated across the medical neighborhood and optimizes the patient experience.
- We will provide whole person care at the first contact. Everyone in the practice – from physicians and practice nurses to medical assistants and frontline staff will practice to the highest level of their training and license in teams, to support better access, self care and care coordination.
- We will be respectful of and responsive to individual patient preferences, needs and values, and ensure that patient values guide all clinical decisions. Individuals and families will get help to be actively engaged in their own healthy behaviors, health care, and in decisions about their care.

What is your role in this process? We ask that you help us coordinate your care. If you seek care elsewhere (without us sending you there), kindly notify us about your visit (self referral to a specialist, visit to the urgent care or emergency room etc). We will obtain and review the records and send necessary information to coordinate your care.

Privacy Use: Patient Consent for Use and Disclosure of Protected Health Information

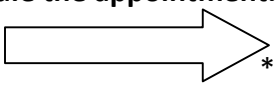
- With this consent, Four Seasons Pediatrics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Four Seasons Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

- I have the right to review the Notice of Privacy Practices prior to signing this consent and acknowledge I have received a copy. Four Seasons Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Four Seasons Pediatrics, LLC Privacy Officer at 532 Moe Road, Clifton Park, NY 12065.

- With this consent, Four Seasons Pediatrics may call my home, cell phone numbers listed with Four Seasons Pediatrics, my work phone if designated by me, mail to my home, email me, or other designated location selected by me and leave a message on voice mail, by text message, or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items, billing and debt collection and any information pertaining to my clinical care, including test results and medical information. I also agree to accept email with PHI attached if I verbally request such information to be sent to my private email.

Financial Policy: Agreement for Payment

No Show/Late Cancellation Charges: Four Seasons Pediatrics cannot bill the insurance for these charges, but are permitted by insurance companies to bill the patient for them. We kindly ask for 24 hours notice if you are unable to come to an appointment previously made. Notifying us 24 hours in advance allows us to offer the appointment time to others. Failure to give 24 hours notice to cancel an appointment previously made is subject to a Late Cancellation charge (currently $25). Failure to show up for an appointment without notification is subject to a No Show charge (currently $50). I understand that if I miss appointments, I will be asked to transfer my records to another doctor and I will still be responsible for the balance owed. Please note - reminder calls are sent out as a courtesy, it is still the patient's responsibility to keep all appointments, unless there is 24 hours notice. **No Show fees and Late Cancellation fees must be paid to reschedule the appointment.**



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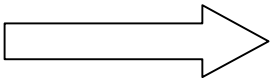
Listing Four Seasons Pediatrics as Primary Care Provider (PCP): I understand that it is my responsibility to notify my insurance company of the change in PCP to Four Seasons Pediatrics prior to my first visit with Four Seasons Pediatrics. Failure to do so will make me responsible for the services rendered during any visits with Four Seasons Pediatrics.

Co-Payments are due at the time of the office visit. Failure to pay the co-payment at the time of service is subject to a co-pay surcharge (currently $5, subject to change).

Monthly Statements will reflect the amount I owe to Four Seasons Pediatrics. Unpaid balances will have a finance charge (currently $5 per month, subject to change).

Past Due Accounts: Accounts that are past due greater than 60 days are subject to being referred to a collection agency. Four Seasons Pediatrics will make every effort to inform me of this action. It is my responsibility to inform Four Seasons Pediatrics of any change in address, phone numbers, or insurance information important for medical payments and correspondence. Failure to notify Four Seasons Pediatrics of changes in address, phone number or insurance information does not relieve me of my responsibility of any charges incurred or balances due. Once accounts are turned over to collections, I understand that I will be responsible for late fees, and any collection costs incurred. If the account is turned over for legal action, I agree to pay all lawyers fees and court costs incurred by Four Seasons Pediatrics as a result of such action.



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Waiver of Confidentiality: I understand that if this account is submitted to an attorney or collection agency, if Four Seasons Pediatrics has to litigate in court, or if my past due status is reported to a credit reporting agency, the fact that I received treatment at your office may become a matter of public record.

Returned Checks: There is a fee (currently Four Seasons Pediatrics is charged $32) that will be passed on to me for any checks returned by the bank for insufficient funds.

Fees: I understand that Four Seasons Pediatrics may reasonably adjust the above fees, from time to time based on fees incurred by Four Seasons Pediatrics, and that these fees are re-assessed on an annual basis.

Copying of Records: I will need to request in writing and pay a reasonable fee (currently $0.75 per page) if I want copies of my records.

Forms

Forms completed during a physical appointment

- Four Seasons Pediatrics has developed computer generated forms. These forms are developed from state requirements and meet the demands for almost all situations. Forms generated from our system at the time of your child's physical exam will be given on request free of charge. The physical forms are good for one year and can be used for sports and camp (unless they have specific custom forms) so if you think you may need one for the upcoming year let our staff know. You will be given one copy. Additional copies or a computer generated form at times other than while you are in the office during your child's physical will be charged a fee of $5 per form, $1 additional if mailed to your home. Forms for siblings will also be charged this fee, unless they are requested at the time of their separate physical exam. School forms require an annual exam done within 12 months of the request.

Forms completed during a sick visit

- Forms will be filled out at no charge if they are related to the sick visit (e.g. note to return to daycare/school/work, note to administer medication related to a sick visit) and they are requested at the time of the visit. Additional copies or a request for a form not done while you are in the office at the time of the visit will be subject to a fee of $5 per form, $1 additional if mailed to your home.

Custom forms

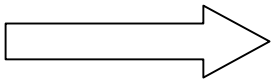
- While our computer generated forms will be applicable for almost all school and daycare forms there are some school, daycare and organizations that require their own custom forms to be filled out. The fee for custom forms is $5 per form, $1 additional if mailed to your home. This fee applies for custom forms done at any time whether done in the office at your child's physical exam or not.

Turn around time

- Although we usually accomplish these in a shorter time frame, please allow a turn around time of up to 2 business days for forms. In addition to the $5 form fee if the form is needed within 24 hour time period there will an additional fee of $5 per item. There is a fee of $ 1.00 for mailing the forms.

Form release

- Due to the Health Insurance Portability and Accountability Act ("HIPAA") regulations, forms will be released to parents or guardians only, unless a 3rd party release form is submitted or on file. We will mail forms to the home address on file at your request, subject to the above fees. All forms must be paid for before they are released.



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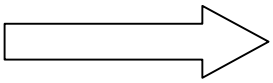
Vaccine compliance policy

- **Four Seasons Pediatrics has an office wide policy that requires the vaccination schedule recommended by the American of Pediatrics (AAP) and The Center for Disease Control (CDC). This policy requires pediatric and adolescent vaccination compliance for all patients. This policy is in effect to protect patients in the practice who have Immune Deficiency, those who have had Bone Marrow Transplants, those being treated with chemotherapy, and Newborns too young to be vaccinated. I understand that failure to follow the Vaccine Schedule within 2 weeks of notification will result in discharge from the practice. This policy does not apply to the flu vaccine nor the HPV vaccine, though the practice strongly recommends both of these vaccines.**



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I have ☐ **received a copy (please request copy)** ☐ **read and declined a copy** of the Four Seasons Pediatrics Patient consent for Treatment, Payment and Healthcare Operations, and understand the responsibilities of me and Four Seasons Pediatrics, LLC. **This is also sent to you through our patient portal when you a web enabled as well as being available on our web site, fourseasonspediatrics.com.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures or provided services in reliance upon my prior consent. If I do not sign this consent, I understand that Four Seasons Pediatrics is under no obligation to provide treatment to me.

I authorize the use of my signature for all my insurance submissions and to carry out activities related to treatment, payment and healthcare operations with all my insurance companies. I understand that I am responsible for any fees not covered by my insurance company, unless my insurance company prohibits billing for such services. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. The individual signing below will be responsible for all financial and billing activities.

_____ _____ _____

Printed Name **Signature** **Date**