REIS PEDIATRICS

KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822

WWW.REISPEDIATRICS.COM

PATIENT – PROVIDER AGREEMENT FORM

Patient name: (list all children) Date(s) of birth:

I,_____, the parent/guardian of the above patient(s) have read and understand the following documents that were given to me to review. I understand that these documents can be found on Reis Pediatrics website.

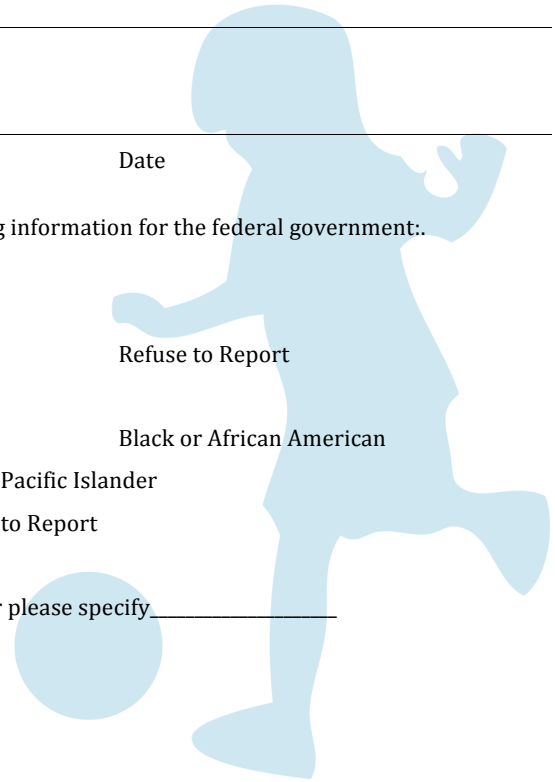
1. Patient-Provider Agreement
2. HIPPA Patient Acknowledgement
3. Patient Financial Responsibility
4. Medicare Lifetime Authorization
5. Insurance Authorization
6. Medical Treatment Authorization

Name of parent / legal guardian

Signature Date

As required by the Affordable Care Act, we have been asked to collect the following information for the federal government:.
Please circle one answer from each question:

1. Ethnicity: Hispanic/Latino Non Hispanic/Latino Refuse to Report
2. Race: American Indian or Native Alaskan Asian Black or African American
   White Native Hawaiian or Other Pacific Islander
   More than one race Refuse to Report
3. Preferred Language: English If other please specify_____



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PATIENT-PROVIDER AGREEMENT

Welcome and thank you for choosing our practice. Our mission is to provide you with the highest quality patient-centered medical care in an environment that is nurturing, empowering, supportive and loving. We are committed to providing your child with the best medical care based on his/her health needs. Our hope is that we can form a partnership to keep your child as healthy as possible.

Your commitment to our patient-centered medical home practice will provide you with an expanded type of care. We will work with both you and other health care providers as a team to take care of you. You will also have better access to us through phone or email on our website: www.reispediatrics.com.

As your primary care provider, we seek to:

- Learn about your child, your family, life situation, and health goals and preferences. We will remember these and your child's health history every time you seek care and suggest treatments that make sense for your child.
- Take care of any short-term illness, long-term chronic disease, and your child's all-around well-being.
- Keep you up-to-date on all your child's vaccines and preventive screening tests.
- Connect you with other members of your child's care team (specialists, health coaches, etc.) and coordinate your child's care with them as your health needs change.
- Be available to you after hours for urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your child's condition(s) and all your options.
- Listen to your questions and feelings. We will respond promptly to you – and your calls – in a way you understand.
- Help you make the best decisions for your child's care.
- Give you information about classes, support groups, or other services that can help you and you child learn more about his/her condition and stay healthy.

We trust you, as our patient, will:

- Know that you are a full partner with us in your child's care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using, and questions you may have.
- **Abide by our vaccination schedule for your child and assure that your child is fully vaccinated by two-years of age.**
- Schedule and attend all well visits required by us to allow better care of your child.
- Let us know when your child sees other health care providers so we can help coordinate the best care for him/her.
- Keep scheduled appointments or call to reschedule or cancel as early as possible or pay a cancellation.
- Understand your child's health condition: ask questions about your child's care and tell us when you don't understand something.
- Learn about your child's condition(s) and what you can do to keep him/her as healthy as possible.
- Follow the plan and steps that we have agreed is best for your child's health.
- Take medications as prescribed.
- Call if you do not receive your child's test results within two weeks.
- Contact us after hours only if your child's issue cannot wait until the next work day.
- If possible, contact us before going to the emergency room so someone who knows your child's medical history can care for you.
- Agree that all health care providers in your child's care team will receive all information related to your child's health care.
- Learn about your child's health insurance coverage and contact your insurance if you have any questions about your benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for your child.

We look forward to working with you and your child in our patient-centered medical home!

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HIPAA PATIENT ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **NOTICE OF PRIVACY PRACTICES**, which contains a more complete description of the uses and disclosures of my health information.

I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization or refer to www.reispediatrics.com at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgment in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

MEDICAL TREATMENT AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any information or the medical status of the minor child referred to on the signed agreement form. I authorize Reis Pediatrics to perform any and all forms of treatment, medication, and therapy with my informed consent in connection with the patient's diagnosis and treatment plan. I also authorize Reis Pediatrics to perform or order any diagnostic procedure(s) and/or test(s) deemed appropriate to make a thorough diagnosis. I authorize Reis Pediatrics to administer such treatment, as they may deem necessary for the patient's diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Permission to Treat a Minor (Under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Reis Pediatrics to treat my child in their office or appropriate treatment facility as required by the events of that emergency situation.

INSURANCE AUTHORIZATION

Assignment of Insurance Benefits: I hereby authorize payment of medical benefits directly to Reis Pediatrics. I further authorize the release of any medical information necessary for processing the insurance claim and any referral necessary for the care of the patient. I permit a copy of this authorization to be as valid as the original. I understand that all costs not paid by the insurance will become my responsibility unless otherwise prohibited by state or federal regulations. **I understand that if I do not inform Reis Pediatrics of changes in my insurance coverage within 30 days from the date of service that I may be responsible for any charges incurred due to a delay in timely submission of charges**.

MEDICARE LIFETIME AUTHORIZATION

If the patient is covered by Medicare/Medicaid, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about the minor child named herein above to release to the Social Security Administration, it's agencies, intermediaries, or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on the patient's behalf I assign the benefit payable for physician services to Reis Pediatrics or the organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also authorize Reis Pediatrics or the organization to appeal any denial of benefits on the patient's behalf.

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Insurance Claims/Payment: As a courtesy, Reis Pediatrics will file your insurance claims for you; however, in the event that your insurance company denies payment for any reason or has not paid within 45 days, the parent(s) and/or guarantor will be responsible for any balance due. It is also the parent(s) and/or guarantor's responsibility to provide current insurance information, including the insurance subscriber number and mailing address, and to follow up on any benefit questions with the insurance carrier. **You are responsible for informing Reis Pediatrics of changes in insurance coverage within 30 days from the date of service, you may be responsible for any charges incurred due to delay in timely submission of charges.** We must emphasize that we are a medical care provider; our relationship is with the patient and not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Patient Account Charges and Statements: Co-Payment and/or any balance due on your account are requested at the time of your scheduled visit; we accept cash, check, and credit card. If you have no insurance plan at the time of your visit you will be required to pay 100% of the visit charges before being seen by our practice. You may contact our billing personnel to arrange and sign a monthly payment plan agreement if necessary. Reis Pediatrics may impose a collection fee and interest charge of 1.5% per month on any unpaid balance. In addition, a billing charge of $5.00 may be charged for each statement a patient receives after the initial one.

Collections: If your account is over 90 days old with no payment activity, your account will be transferred to a collection agency. A $35.00 fee will be added to your account upon transfer. If applicable, the parent(s) or guarantor is responsible for all related expenses incurred in the collection of the delinquent amount due. These may include, but are not limited to attorney's fees and/or other costs that Reis Pediatrics considers necessary in order to collect the delinquent amount due. To avoid collections, please be sure to pay your co-pay/balance at the time of your visit or mail in your payments by the due date shown on your statement.

Returned Checks: All returned checks are subject to a $25.00 NSF fee and any bank fees incurred. In addition to the returned check, and the NSF fee & bank fees, you will also be required to pay any outstanding balance by your next scheduled visit. As a result, you may be placed on a cash/credit card only payment method for future appointments.

No Show and Cancellation Charges: As a courtesy to our physicians, staff, and other patients, we ask that you cancel your appointments at least 24 hours in advance. There is a $35.00 fee for not showing up for or cancelling your well visits/physicals with less than 24 hours notice. If missing regular sick or follow up visits becomes a habit, you may be charged the $35.00 fee as well. True emergencies will be handled accordingly between the parent(s)/guarantor and the office manager.

Credit Card Payment Authorization: **(OPTIONAL)**: We request that your credit card information be on file with us to process any outstanding balances on your account. Our billing specialist will notify you before any transaction and will mail a receipt to your billing address.