Laurel J. Schramm, M.D., F.A.A.P.

Financial, Privacy and Vaccine Policy

Payment by Insurance Company: I authorize Dr. Schramm to submit each visit and service to my insurance company on my behalf. I authorize the release of any medical or other information for the purpose of providing care or securing payment for services rendered. I authorize the payment of medical benefits directly to Dr. Schramm. *Initial* _____

Patient Responsibility: I agree that I am financially responsible for any charges not covered by my insurance carrier including but not limited to: co-insurance, co-payment and/or deductibles. I understand and agree that if my insurance company subsequently notifies Dr. Schramm that a rendered service is not a covered benefit of my insurance plan, I am to pay the full amount not covered. If the credit card on file cannot be charged and the parents are divorced or separated, the parent who brought the child to the visit is financially responsible for that visit.

Initial _____

Screening: During well visits we perform medically indicated tests to screen for conditions such as vision or hearing problems, anemia, or high cholesterol. Be aware that occasionally insurance may not not cover this charge. Screenings usually performed at each age are posted on our website so that you can determine what is covered by your plan.

Initial _____

Insurance Coverage for Well Visits vs. Problem-Oriented Visits:
Well visits are meant for evaluation of growth, nutrition, development and screening for any health conditions. Well visits may uncover new problems or revisit ongoing issues that require evaluation and management. Common examples include ear infection, stomachaches, ADHD and asthma. It is our preference whenever possible to address such problem-oriented issues at the same office visit. This is a convenience so that families do not have to return for another appointment. In compliance with insurance company billing policies we then must report the codes and charge for both a well visit and problem-oriented visit. While well-child visits may not require a copay, problem-oriented services typically do prompt a copay/coinsurance/deductible.

Initial _____

Appointments/After Hours: Visits are by appointment only. Patients arriving more than 15 minutes late will be rescheduled to an appointment later that day, if available. Three “no-shows” per family will result in dismissal from the practice. Business hours are 9am-5pm Monday through Friday. Services rendered outside of these times are considered after hours which may result in an additional charge to you, depending on your insurance plan. *Initial* _____

Credit Card Policy: We are committed to making our billing process as simple and easy as possible. We require a credit card on file within 30 days of the first visit of a member of your family, or by 9/1/19 for existing patients. After your insurance processes the claim and determines the amount that is patient responsibility, our office will charge your credit card. If the amount is over $100, we will call you to get your authorization to charge the full amount or start a payment plan. If we are unable to reach you within 48 hours, we will start a payment plan of $100/month. It is your responsibility to update your credit card on file when it expires or is replaced.

Initial _____

Administrative Fee: The annual administrative charge of $150 per family includes form completion, medical letters of necessity, non-medical forms such as FMLA, disability and life insurance and patient portal use. This fee is the responsibility of the parent and cannot be submitted to any insurance carrier and is due within 30 days of the first visit of a member of your family, or by 9/1/19 for existing patients. After the initial payment it will be charged annually to your credit card until your children are no longer patients of Dr. Schramm and their accounts reflect a zero balance. *Initial* _____

Privacy Practices: I understand that the patient's health information is private and confidential. I understand that Dr. Schramm's office may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I have read a copy of Dr. Schramm's Notice of Privacy Practices. It contains more information about the policies and practices protecting the patient's privacy. This notice is posted on doctorschramm.com and I may be given a written copy at any time upon request. *Initial* _____

Vaccine Policy: I understand that Dr. Schramm recommends immunization in accordance with the American Academy of Pediatrics Guidelines. I understand that Dr. Schramm does not accept patients that do not vaccinate according to the vaccine policy available on doctorschramm.com. *Initial* _____

Permission to Treat: I understand that by signing below I authorize Dr. Schramm to provide medical care to my child(ren). *Initial* _____

Acknowledgment of Financial, Privacy and Vaccine Policy and Permission to Treat

Signature of parent/guardian/patient (if over 18): _____

Printed NAME of parent/guardian/patient (if over 18): _____

Date: _____

Patient name/DOB: _____

Patient name/DOB: _____

Patient name/DOB: _____

Patient name/DOB: _____

Patient name/DOB: _____