Field Pediatrics, P.C.
1106 Gleneagles Drive
Huntsville, Al 35801

Patient_____

DOB_____

GENERAL POLICIES AND RESPONSIBILTIES

ESTABLISHMENT AS OUR PATIENT(S): See separate sheet.

POWER OF ATTORNEY: If grandparents, neighbors, etc., will be counted on to bring your child(ren) in the future, please ask for a form for you to fill out so that we can legally be authorized by that caretaker to provide needed medical services.

MEDICAL RESPONSIBILITY: Our staff is committed to provide the best quality medical care for your child(ren). To achieve this goal, we need your cooperation in complying with our medical advice as well as appropriate preventative health care (i.e., checkups) and follow-up visits. Checkups are done yearly through 5 years of age and done *at least* every other year after that. Failure of the parent or guardian to reasonably comply with such plans is grounds for termination of our physician-patient relationship.

Date _____ Parent/Guardian's Signature _____

FINANCIAL RESPONSIBILITY: All legal guardians (who are generally both parents) are responsible for reimbursing us for services rendered to their child(ren) regardless of divorce decrees, etc.

Health insurance is purchased by patient families and is directly responsible to them. Since insurance companies often do not pay for services or proportions of services that families or individuals think they should, payment (at least co-pay) is expected from the guardian who brings the child at the time of service. A $20 fee will be added to the account if a co-pay is not paid within 2 billing cycles. You will generally be asked to pay at the time of service for procedures not covered by insurance like metabolic screens, hemoglobins, urine analyses, PPD's and audiograms. We do not charge for vision screens.

Failure on the guardian's part to make an attempt to pay some amount (even a small amount to show good faith) on a balance owed each month is grounds for termination of our physician-patient relationship and for sending the account to collections. Regardless of when payment for services is received, the undersigned is financially responsible for all charges.

The undersigned hereby agrees to abide by the above policies and to pay a reasonable attorney's fee and all expenses incurred in the event this account is turned over to an attorney for collection.

Date _____ Parent/Guardian's Signature _____

OTHER CHARGES: Due to high overhead costs and unpredictable scheduling, a charge of $25 will be made to your child's account for missed appointments. There will also be a $25 charge for letters written on your child's behalf by our physicians. Forms (sports physical, camp, college, school medicine forms, etc.) and multiple prescriptions filled out between scheduled visits may incur a $20 charge. We do not charge extra when such forms and prescriptions are done at a scheduled visit. These charges are not billed to insurance. Payment is expected when the forms are picked up.

Date_____ Parent/Guardian's Signature _____

RELEASE OF MEDICAL INFORMATION: I hereby authorize the staff at Field Pediatrics, P.C., to release any information pertaining to my child(ren) to involved insurance companies as well as to other medical or paramedical persons who may be involved in the care of my child(ren).

Date_____ Parent/Guardian's Signature _____