

Church Hill Pediatrics and Adolescent Medicine, LLC

www.churchhillpeds.com
mail@churchhillpeds.com

32 Church Hill Road
Suite 200
Newtown, CT 06470

Tel. (203) 426-KIDS
(203) 426-5437
Fax (203) 426-2100

Patient Name: _____

Date of Birth: _____

Parent / Guardian: _____

Insurance Carrier: _____

Initial Each
Box

- It is the responsibility of the 'responsible party,' parent, or guardian to understand what procedures are (or are not) covered by a specific policy or insurance contract. It is the insurance company that determines whether copayments and or deductibles are required.
- Following standard and customary billing practices, Church Hill Pediatrics and Adolescent Medicine will submit a claim for all procedures, including the evaluation and or management of specific conditions.

- **The well-child care visit does not include the evaluation or management of acute or chronic conditions, such as physical complaints or behavioral/emotional conditions (whether an initial assessment or a follow-up thereof; this includes medication management)**
- **During the well-child visit, a healthcare provider may identify or diagnose a condition that requires a 'separately identifiable' evaluation/management service and/or claim.**

- Church Hill Pediatrics and Adolescent Medicine follows recommendations of the American Academy of Pediatrics with regard to routine well-child care. Church Hill Pediatrics and Adolescent Medicine will submit a claim to your insurance company. The fees associated with these procedures and their coverage are negotiated with and or dictated by insurers. **Your insurance company may also require you to accept financial responsibility; though the majority of procedures are covered** by most insurers.

- Vision screening
- Hearing screening
- Testing for lead and anemia
- Urine screens for gonorrhea and chlamydia (All 16 years +)
* The lab will file a claim with your insurance company.
* **The default lab will be Danbury Hospital unless specified**
Please circle which lab you would like to use

Circle One
DH Quest

- Vaccines and or vaccine administration
- Depression and or other emotional screenings
- Substance abuse screening
- Autism and or other behavioral screenings
- Procedures performed, regardless of complexity
- Evaluation and management of specific concerns
 - Acute conditions or symptoms
 - Chronic conditions or medication follow-ups
 - **Conditions identified during the well-visit**

Signature of Responsible Party

Date

REFUSAL or OPT OUT of ANY PROCEDURE

- **By refusing or opting not to perform these procedures, you agree to hold Church Hill Pediatrics and Adolescent Medicine, LLC harmless** for failure to identify and/or adequately manage conditions that may have significant consequences.
- You may schedule a separate visit with us or another physician (specialist) to assess or discuss any conditions or concerns you may have.
- Church Hill Pediatrics and Adolescent Medicine may not be able to participate in the continued care of patients who regularly refuse these standard, recommended, and important procedures.
- While your child's health is paramount, we recognize that this may create financial hardship for some. We will work with you to ensure all considerations are discussed

Signature of Responsible Party

Date

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Financial Responsibility Form

Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusion and limitations, and authorizations requirements. This information can be obtained by contacting your insurance carrier. If your coverage is not in effect at the time of the visit, the financial responsibility for that visit will be yours.

- **If you have had any changes in your insurance coverage, you must notify us.**
- **Presentation of your insurance card is required at every visit for each child. Regardless of change or prior visits.**

CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES

Co-payments, co-insurances, and deductibles are your responsibility. As defined by your insurance company and must be collected at the time of each visit or service. In the absence of information regarding your deductible balance (to which we have limited-if any-access) you will be required to pay your deductible for the entire visit or a portion there of.

Effective **November 1st, 2024**, Patients with deductible/co-insurance plans, will be required to pay **\$75** at the time of the visit.

NO INSURANCE CARD/SELF PAY

Patients without valid insurance information are considered self-pay patients and are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to your visit. You will be responsible for any claims that cannot be filed due to inaccurate insurance coverage documentation.

- **Should you have insurance but are unable to present (a copy of your card) at the time of your visit, you will be asked for a credit card, to be kept on file and authorized for a cash payment or charge**

You may also email a copy of your insurance card, front and back within 24 hours of your visit to:
mail@churchhillpeds.com

By Signing and dating this form, I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered services. Co-payments and deductibles are due at the time of service. In the event my health plan determines a service to be "not covered", I will be responsible and agree to pay for the costs of service provided. If I am uninsured, I agree to pay for the services rendered to me at the time of service.

Signature of Patient, Authorized Representative or Responsible Party

Date

Print Name of Patient, Authorized Representative or Responsible Party

Date

We accept cash, check, and credit card
Please make checks payable to Church Hill Pediatrics and Adolescent Medicine

Authorization Form: Card on File

Information to be completed by cardholder:

The undersigned agrees and authorized Church Hill Pediatrics and Adolescent Medicine to save the credit card indicated below on file. This may be used in the event that insurance information is missing, invalid, or self pay.

Patient's Name: _____

Name as it Appears on the credit card:

Type of Credit Card: MasterCard Visa Amex Discover

Card number: _____

CVC2# _____ Expiration Date _____ Zip Code _____

I, _____ authorize the above Church Hill Pediatrics and Adolescent Medicine to store the above credit card information as the "Card on File". I understand this authorization will remain in effect until the expiration of the credit card or upon your written request to revoke this authorization. Patient may also revoke this form by submitting a written request to Church Hill Pediatrics and Adolescent Medicine.

Cardholder's Signature

Date

Print Name of Cardholder