Parkway Pediatrics, LLC- Dr. Kelli Cocke, M.D.
Parkway Pediatrics, LLC. is a physician owned and operated facility.

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information. Our Full Privacy Policy Form/Patient Policy and Insurance/Billing Policy can be found on our website at pkwypeds.com, posted in our office lobby or you can request a copy.

Consent Related to Privacy Notice:

I have reviewed the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change at any time. I may obtain these revised notices by contacting the practice by phone or in person. I understand I have the right to inspect, copy, receive confidential communications from Parkway Pediatrics, LLC by alternative means, have the physician amend and request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but Parkway Pediatrics, LLC is not required to agree to my restrictions.

Consent for Care:

I, with my signature, authorize Parkway Pediatrics, LLC, Dr. Kelli Cocke M.D. and any employee working under the direction of the physician, to provide medical care for me, or the patient for which I am the legal guardian of. Medical care, services and supplies related to myself/patients health, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, immunization/vaccine administration, assessment or review of physical or mental health of the body and the dispensing of prescriptions, samples, devices/equipment or other items required. This consent may include contact and discussion with other health care professionals for care and treatment.

Patient Policy:

I have reviewed the Patient Policy as part of this registration process. I understand that patients must be present at the time of appointment. I agree to cancel all appointments within a reasonable time, unless due to an emergency. I understand that 3 “no-shows” or 6 “last minute cancellations” for appointments will result in dismissal from our clinic. I also understand and agree that arrival of more the 20 minutes late for my/patients appointment will be marked as a “no-show” or “last minute cancellation” and I will be asked to reschedule. All “no shows” for ADD/ADHD appointments will result in denial of ADHD medicine refills until patient is seen.

Financial Policy:

I, the patient/responsible party assume responsibility to ensure that the financial obligation is fulfilled for the health care services received. I also authorize this practice to furnish information to the billing office in connection to Parkway Pediatrics,LLC and identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice.

*I understand that I am responsible for all balances, co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I understand that if I have an insurance co-payment, co-insurance or deductible charge I am expected to make that payment when checking in for my appointment. I also understand I am required to pay 20% of any balance over $300 before I can be seen. I understand that if my balance is below $300, I/patient will still be seen, however, a payment or payment plan must be made prior to being seen.

*I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Parkway Pediatrics, LLC. is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

*I understand that a wellness visit consists of an exam and any vaccines that are required by age. I agree that any additional concerns will constitute a “problem” visit in addition to the wellness visit and result in a charge from our office or the patients insurance. If you do not advise the front office staff and do not pay the co-pay, co-insurance, or deductible charge you/patient will be billed.

Authorization to Communicate: I understand that Parkway Pediatrics, LLC utilizes various communication methods including voice calls, email and fax for the purposes of sharing clinical/ medical results, scheduling appointments, sending appointment reminders and communicating/ discussing financial responsibilities. By signing this form, I am granting permission to Parkway Pediatrics, LLC to utilize all phone numbers/addresses that I have supplied to contact me regarding this current visit and any future visits for the above stated purposes. I further understand that I have a right to revoke this authorization at any time by communicating this request to Parkway Pediatrics, LLC.

Release of Information: I authorize Parkway Pediatrics, LLC to release medical or other information to my primary care or referring physicians, the insurance companies, the Louisiana Department of Health and Hospitals (Medicaid and SSI), or any third party acting on my behalf or Parkway Pediatrics, LLC’s behalf which is needed for benefits to be paid under my insurance or other contracts applicable to claim for treatment. I hereby indemnify and release Parkway Pediatrics, LLC from any and all responsibility relative to the release of such information. I understand that Parkway Pediatrics, LLC will make any disclosures that are required by law to meet mandatory reporting requirements. I hereby idemnify and release Parkway Pediatrics, LLC from any and all responsibility relative to the release of such information.

I have read and understand **ALL** of the above Policies/Consents and agree to accept full responsibility as described above.

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Patient Name

_____ _____

Patient Guardian Signature **Date**