**Thank you for choosing *Knoxville Pediatric Associates* as your child(ren)'s health care provider!**

## OUR FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. Therefore, financial responsibility for your child(ren)'s treatment is ultimately that of the parent/guardian. Parents/Guardians are responsible for all co-pays and deductibles prior to services being rendered. If you have an insurance which we do not participate with, it is your responsibility to pay at the time of service unless payment arrangements have been made with our business office. Any account referred to a collection agency will have a service charge added. A service charge of $20 will be added for any checks drawn on insufficient funds. For your convenience we accept cash, check, and Visa/MasterCard/Discover credit cards or debit cards.**The parents/guardian seeking medical treatment for the child is responsible for any bill incurred, regardless of any divorce decree or court order stating otherwise.**

## OUR OFFICE POLICY

A patient that is not seen within a 3 year span will be considered a new patient and charged accordingly.

Prescription refills will only be approved during normal business hours. It is not our policy to call in medications without the child being seen first, unless it is a refill.

## PERMISSION TO CONTACT

- ◯ Leave lab results on my answering machine
- ◯ Leave lab results with my family
- ◯ Leave general questions/medical information on my answering machine
- ◯ Leave general questions/medical information with a family member
- ◯ ONLY leave information with myself *Please note if you check here, there should be no other choices marked.*

**The following people are authorized to bring my child for any necessary medical treatment, speak with the staff at KPA regarding my child, or sign any consent forms in my absence**: (please list someone other than parent/guardian)

| **Name** | **Relationship to Patient** | **Phone** |
|---|---|---|
| | | |
| | | |

**Emergency Contact** (please list someone outside of household)

| **Name** | **Relationship to Patient** | **Phone** |
|---|---|---|
| | | |

**Your signature below allows us to**:

1. Accept payment of benefits directly from your insurance company under the terms of your insurance. Release medical records to your insurance, hospitals, any physician, and attorneys for the purpose of determining benefits, coordination of care, or legal matters.
2. Obtain necessary information from your child(ren)'s other health care providers.

**Your signature below also indicates your acknowledgement that you have been provided with a copy of the Notice of Privacy Practices Policy (HIPAA), that you have read and understand KPA's Financial and Office Policies as described above, and that your answers regarding contacting you regarding your child and permission for someone other than you may seek medical treatment are accurate.**

**Signature:**_____**Relationship:**_____**Date:**_____