



# Boston Children's Health Physicians

Until every child is well™

formerly CWPW

## PATIENT FINANCIAL POLICY

Thank you for choosing Boston Children's Health Physicians as your (your child's) health care provider. Please be assured that your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

### Co-Payments

We are required to collect your co-payment at the time of visit. There will be a \$15 surcharge applied to your balance if your co-pay is not paid at time of visit. BCHP accepts cash, check or credit cards.

Some insurance plans charge multiple co-pays for services provided on the same day. If you have any of those services you may be billed for additional co-payments after the visit.

### No Show/Late Cancel Policy

A \$40 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel prior to the late cancel period. Please consult with your physician's office for specific information about the late cancel period.

### Insurance

We will require a copy of your (or your dependent's) insurance card for our files. Please also inform us of any change in your insurance coverage.

### Participating Plans

BCHP participates in most insurance plans. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.

### Non-Participating Plans

If we are out of network for your insurance and your insurance pays you directly, payment is due at time of visit unless other arrangements have been made prior to the visit.

### Referrals

If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

### Self-Pay

Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

## PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a \$15 surcharge will be added to my bill in addition to the applicable co-pay charge.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Parent or Authorized Person

\_\_\_\_\_  
Print name of Parent or Authorized Person

\_\_\_\_\_  
Date



## NO SHOW POLICY

### Dear Parent,

In an effort to serve our patients and to ensure that our available appointment times are used appropriately, BCHP has implemented a NO SHOW policy for all of our patients effective April 1<sup>st</sup>, 2014.

You will be billed \$40 if your child misses an appointment and you have not contacted us to cancel at least 24 hours prior to the scheduled appointment time. If the appointment is on Monday, you must contact us by the Friday before.

If your child misses 3 appointments in a row, he/she may be discharged as a patient of this practice.

To cancel an appointment, please call your physician's office. If you do not reach the secretary you may leave a detailed message on the voice mail. Please include the date and time of the call. You may not cancel an appointment by email.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ (patients 18 & over)

Parent Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_



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I hereby acknowledge that a copy of *Boston Children's Health Physicians, LLP's* (hereinafter BCHP) Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about BCHP's privacy practices or my rights with regard to my personal health information, I may contact BCHP's Privacy Officer for further information as set forth in the Notice.

\_\_\_\_\_  
 Name of Patient – Please Print Name

\_\_\_\_\_  
 Name of Parent or Guardian

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Signature of Parent or Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

**DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN  
 ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Identification #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I hereby certify that on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ I made a good faith effort to obtain the above patient's written acknowledgment of receipt of BCHP's Notice of Privacy Practices, but I was unable to do so for the following reason(s):

Name of Staff Person (Please Print Name) \_\_\_\_\_

Signature of Staff Person \_\_\_\_\_

Date \_\_\_\_\_

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.



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E-mail offers an easy and convenient way to communicate but is not the same as calling your physician's office. You can't tell when your message will be read or responded to, or even if your doctor is readily available or on vacation. Children's and Women's Physicians of Westchester LLP ("BCHP") will communicate with our patients (or their parents or guardians) by email only if we receive your agreement to the terms set forth in this Consent. Your consent to these terms will apply to all BCHP clinical providers as well as non-clinical personnel of BCHP who are involved in your care, scheduling, billing and other activities.

- **Use of e-mail is never appropriate for urgent or emergency health problems!** You must call your physician's office or go to a hospital Emergency Department.
- **BCHP WILL NOT ENGAGE IN OR RESPOND TO TEXT MESSAGING BY USE OF A CELL PHONE OR SIMILAR MOBILE DEVICE.**
- E-mail is not to be used as a substitute for face-to-face medical consultation with your physician and is at your physician's sole discretion.
- E-mail is appropriate for communicating regarding routine matters that don't require a lot of discussion, such as prescription refill requests, referral and appointment scheduling requests and billing/insurance questions. BCHP may utilize e-mail at its discretion to send you information about our practice and services, including appointment reminders, our patient programs and new services.
- Your use of e-mail is not confidential and it may not be encrypted. It is like sending a postcard through the mail. Our staff (clinical and non-clinical) may read your e-mails in the course of their work duties. If you send e-mails through a work email account, your employer may have the legal right to read your email.
- E-mail should never be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mail may become a part of the medical record when it contains clinical information, and we believe it is appropriate to include it in the medical record. In such case, the message may be retained in the patient health record.
- By signing below, you represent to BCHP that (a) you are the patient or parent or guardian of **the minor child or person lacking capacity to consent to their treatment** listed below; (b) you are an authorized user of the listed email account, (c) you have authority to consent to our use of the account for communications concerning the patient; and (d) you accept full responsibility for monitoring the security of use of the email account on your end. You agree that BCHP will have no responsibility to use any measure to verify that the recipient or sender utilizing your email address is you.
- Either party can revoke permission to use the e-mail system at any time in writing.
- This email agreement **ONLY** covers the individual signing below. Each authorized representative of the patient must sign his own email Consent.

I wish to communicate by e-mail with BCHP concerning the patient listed below upon the terms of this Consent.

Patient Name: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your E-mail Address: \_\_\_\_\_ your state of residence: \_\_\_\_\_



## RACE & ETHNICITY PATIENT FORM

The U.S. government now requires that we ask patients for their race and ethnicity. You have the option to provide this information or to decline by checking the box. All responses will be kept confidential.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Which category best describes the patient's race?
  - American Indian/Alaskan native
  - Asian
  - Native Hawaiian or other Pacific Islander
  - White/Caucasian
  - Black or African-American
  - Other
  
2. Which category best describes the patient's ethnicity?
  - Hispanic or Latino or Spanish origin
  - Not Hispanic or Latino or Spanish origin
  
3. What is the patient's preferred language?
  - English
  - Spanish
  - Other \_\_\_\_\_
  
4.  I do not wish to provide this information

*Thank you for your time.*