Patient Information

Please complete forms below. Once completed, please print, sign, and email them to DrRoma@DrRomaFranzia.com

Patient's name (#1) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Patient's name (#2) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Patient's name (#3) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Patient's name (#4) ____

Nickname ____________________ Gender _____ Date of Birth ____ /____ /_____

Parent #1's Name ____________________________Date of Birth ____/____/_____

Home address ____

City _______________________________________State _____ Zip ______________________

Home # ________________ Work # _______________ Cell # _________________________

E-mail address: _____________________________ Fax # ______________________________

Which number do you prefer to be called at by our office? __________________________________

Can confidential medical information be left on this number's voicemail? Yes or No

Parent #2's Name ______________________________________ Date of Birth ____/____/_____

Home address (If different from above) ____

City __________________________________ State __________ Zip ________________________

Home # _______________ Work # ______________ Cell # ______________________________

E-mail address: _____________________________________ Fax #_________________________

Which number do you prefer to be called at by our office? ___________________________________

Can confidential medical information be left on this number's voicemail? Yes or No

EMERGENCY INFORMATION

If parents are unavailable, authority is given to contact the following person in case of an emergency:

Name:______________________________ Relationship:_____________________

Home # ____________________Work # ___________________Cell # ________________________

INSURANCE INFORMATION

Insurance company ____

Group # _______________________ Identification # ______________________________________

Name of primary insured _______________________ Relationship to patient ____________________

Birth Date of primary insured _____ /____ /_____ Social Security # ______-______-______

Name of employer ___________________________________

Whom may we thank for referring you? ____

I authorize the release of any information concerning my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. In lieu of payments which would otherwise be payable to me, I hereby authorize payment directly to the doctor.

Signature ____ Date ____/_____/_____

HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address listed on this form to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ________________________________

Signature: ____________________________________

Relationship to Patient: _________________________

Date: ____

542 Lincoln Avenue, Winnetka, IL 60093

Financial Policy

Effective September 2021

1. **It is our pleasure to process each insurance claim** through our billing department; however, **it is your responsibility to verify coverage** prior to your appointment. Not all insurance plans cover all pediatric services. The fact that an insurance plan may not pay for a particular service does not mean that your child should not receive it. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. To facilitate a claim, a copy of your driver's license and insurance card will be required.

   Initials: ______

2. **Co-payment is due at the time of service.**

   Initials: ______

3. **Self-pay Patients:** Payment on the day of the examination is due. Kindly refer to the "Fees for Service" price list.

   Initials: ______

4. **Out-of-Network Provider:** If your insurance company does not have a contract with Dr. Roma Franzia Pediatric Practice, you are considered to be out-of-network. You will be responsible for the out-of-network balance owed.

   Initials: ______

5. **Cancellation:** An appointment may be cancelled up to ***4 hours prior*** to the scheduled time.

   Initials: ______

6. **No Show:** If a scheduled appointment results in a "No Show," **a fee of $75** will be charged to your account.

   Initials: ______

7. **Walk-in appointment:** If your child arrives at Dr. Franzia's Pediatric Practice without a scheduled appointment, your insurance company will be charged an additional $25/emergency visit.

   Initials: ______

8. **Prescription refills**: Anytime a patient requires a prescription refill without an appointment, your insurance company will be charged **$35 for the medical documentation**.

   Initials: _____

9. **Speaking with a physician during office hours:** A simple conversation with a physician during office hours is free. A medical decision making conversation requiring documentation, and perhaps a prescription, is a **"Tele" charge** that will be billed to your insurance company which will result in a co-pay/balance that you will be responsible to pay. Most insurance companies have allowed for this charge due to medical/legal responsibility.

   Initials: ______

10. **Speaking/texting/emailing with a physician after office hours:** A telephone/text call will be responded by a physician as soon as possible. Emails will be answered the next day. A "**Tele" charge** will be billed to your insurance company which will result in a co-pay that you will be responsible to pay. Most insurance companies have allowed for this charge due to medical/legal responsibility.

    Initials: ______

11. **Divorced/Separated Parents:** Due to the complexity of these situations, our policy regarding payment on your account is the **responsibility of the custodial parent**. If you have a settlement that states you split medical bills, it will be your responsibility to work that out with your former spouse.

    Initials: ______

12. **Outstanding Balances:** Once an insurance claim is processed, you will receive a statement. If a balance on your statement is due, it would be appreciated if the payment was made within 30 days. Failure to pay the balance in full within the 30 days of the statement date will result in a late charge of 1.5%. Late charges will accrue monthly until the remaining balance is paid. If you are experiencing financial hardship, please contact our billing specialist, Ritu, at (224) 365-8401 or email: Ritu@DrRomaFranzia.com to make payment arrangements.

    Initials: ______

13. **Notification of Possible Non-Covered Services:** There may be services that Dr. Franzia's Pediatric Practice deems necessary for the maintenance of good health that may not be covered by your "in-network" health insurance. Our practice participates in a vast number of different policies and are not able to know all exclusions on your policy. If your policy declined payment on these services, my office will apply the contracted discount to your services. Payment will be your responsibility.

    Possible Non-covered Charges: Denver Development, Immunizations, and Nebulizer Rentals.

    Initials: ______

I, ____**(name of responsible payer)**, authorize and request my insurance company to pay directly to Dr. Franzia's Pediatric Practice my insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s). I have read and understand Dr. Roma Franzia's Pediatric Practice's Financial Policy.

Signature ____

Family Name ____

Date __________________________

Credit Card Payment

Before a charge is processed, you will be notified.

After a charge is processed, a receipt will be given or mailed to you.

This credit card information will be entered into our Electronic Medical Records System and then shredded for security. Only the last 4 digits of this credit card will be available to our practice.

Method of Payment ⬜Mastercard ⬜Visa ⬜Discover ⬜American Express

Credit Card Number ____

Expiration Date _____________________ **CVV Code** __________________

Signature ____

Name ____

Date ______________________

Once completed, please print, sign, and email forms to DrRoma@DrRomaFranzia.com