Harmony Mills Pediatrics

Walk-In Clinic for NON-Harmony Mills Patients

As part of our partnership with the Cohoes City Schools, we welcome all students in the district to our walk-in hours from 7-9 AM (early arrival recommended to get students to school on time, if cleared). We assume consent to confirm that the patient was seen if asked by the school nurse, as well as to confirm the minimum necessary information about ability to return to school. We will confirm highly contagious diseases (strep throat, coxsackie, scabies, gastroenteritis) to the school, but will not discuss any more personal or health information than necessary to permit the nurses to do their jobs (for example: we would never say "oh by the way, she just started birth control"). If you have any questions, or wish to restrict this disclosure, please see us to provide restrictions in writing.

☐ I understand.

Patient's Full Name: _____ Gender: ☐ Male ☐ Female

DOB: ____/____/____ Ethnicity/Race: _____ OR ☐ decline to answer

Local Address: _____
Street City State Zip

Primary Contact Number: _____ ☐ Home ☐ Cell ☐ Work

Regular doctor: _____ Patient's school: _____

Certain tests (urine cultures and throat cultures primarily) must be sent out to an external lab. We primarily use LabCorp for this. We are not responsible for bills sent to you by the lab. If you have any questions or concerns, please contact your insurance prior to checking out. Upon request, we are also able to use Quest Labs.

☐ I understand.

Primary Insurance Company: ☐ CDPHP ☐ Fidelis ☐ WellCare ☐ MVP ☐ BCBS ☐ United HealthCare ☐ NY Medicaid ☐ TriCare
☐ Other: _____ ☐ No Insurance

Is this policy state funded (i.e. Medicaid, Medicare) or privately funded (through an employer? ☐ State ☐ Private

Policy #: _____ Copay Amount: $ _____

Subscriber/Policy holder (if not the patient): _____
Last First DOB Relationship to patient

Authorization and Acknowledgement of Walk-In Clinic Privacy and Billing Procedures for Harmony Mills Pediatrics

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and on all future dates of service. I understand I may revoke this authorization by informing Harmony Mills in writing, but if I do so it will not affect charges for any services provided prior to the date the revocation is received by Harmony Mills.

Acknowledgement of Receipt of Notice of Privacy Practices and Authorization to Release Information to Family/Friends or Others

I have received a copy of Harmony Mills's Notice of Privacy Practices. I authorize Harmony Mills to release any information regarding my treatment, including lab results, x-rays, and medical records, to the following individuals/entities (Harmony Mills may not release information or records to any individuals/entities unless you identify them here):

- Cohoes City School District (*limited to clearance to return to school, participate in activities, and confirmation of contagious disease relevant to the classroom*).
- Primary Care Physician identified on the previous page.
- Name: _____ Relationship to Patient _____
- Name: _____ Relationship to Patient _____
- Name: _____ Relationship to Patient _____
- Name: _____ Relationship to Patient _____

Harmony Mills will use the phone number and address on the previous page to contact me regarding my child's treatment, including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

Authorization to Treat and Bill

I consent to be treated by Harmony Mills Pediatrics. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Harmony Mills Pediatrics to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Harmony Mills Pediatrics, or to outside labs as described, for all services performed and billed by Harmony Mills. I understand that I am responsible for all charges for the treatment I receive at Harmony Mills. I understand that Harmony Mills providers may utilize the Prescription Monitoring Program service at no additional charge to me.

As a courtesy, Harmony Mills will bill my medical insurance. If I do not provide complete and accurate insurance information to Harmony Mills, I understand Harmony Mills may not receive payment from my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Harmony Mills's bill, I may owe payment for services not covered by my insurance, or subject to a deductible, and I agree to pay these promptly to Harmony Mills. I understand that Harmony Mills may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Harmony Mills is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, Harmony Mills may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay Harmony Mills for services provided to me, the balance owed may be sent to collections and I may incur collection fees of up to 25% in addition to the amount owed for services/treatment rendered. I understand that I may contact Harmony Mills to work out payment arrangements that may prevent this additional cost.

Signature _____ Today's Date _____

Name of Person Signing Above _____ Relationship to Patient _____