YEARLY UPDATE FORM – YEAR 2023

If there are **guardian** changes within the last year due to divorce, death, or fostering, please fill out **new patient paperwork**.

This information applies to the following ***Established Patients*****,** under the age of 18, living at this address:

ADDRESS:_____ CITY/STATE/ZIP:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PARENT(S) OR GUARDIAN(S) GUARANTOR INFORMATION

PARENT / GUARDIAN NAME: _____ DOB: _____ ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER _____

CELL PHONE: _____ EMPLOYER:_____ POSITION:_____

If different than above: ADDRESS: _____ CITY/STATE/ZIP: _____

PARENT / GUARDIAN NAME: _____ DOB: _____ ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER _____

CELL PHONE: _____ EMPLOYER:_____ POSITION:_____

If different than above: ADDRESS: _____ CITY/STATE/ZIP:_____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND WE MAY CONTACT **AT A DIFFERENT ADDRESS**:

NAME:_____ PHONE:_____ RELATIONSHIP TO PT:_____

PATIENT PORTAL ACCESS

Best email for **PARENT (PROXY) PORTAL ACCESS**: _____

For children aged **13 and older**, please provide their email address for **PATIENT (PRIMARY) PORTAL ACCESS**:

PATIENT NAME:_____ AGE:_____ EMAIL:_____

PATIENT NAME:_____ AGE:_____ EMAIL:_____

PATIENT NAME:_____ AGE:_____ EMAIL:_____

PATIENT NAME:_____ AGE:_____ EMAIL:_____

PATIENT NAME:_____ AGE:_____ EMAIL:_____

PATIENT NAME:_____ AGE:_____ EMAIL:_____

PARENTAL/GUARDIAN DESIGNATION AUTHORIZING TREATMENT OF A MINOR

I authorize GATEWAY PEDIATRICS, LLC, to discuss and provide medical treatment of the minors (listed on page one) with the following authorized adult(s) who are over the age of 18 (e.g.: Grandparents, Siblings, Aunts/Uncles, Step-Parents, etc.)
These persons have my permission to bring my child to their appointments:

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

NAME:_____ RELATION TO MINOR:_____ PHONE:_____

_____	_____	_____
SIGNATURE OF PARENT/GUARDIAN	**PRINT NAME OF PARENT/GUARDIAN**	**TODAY'S DATE**

I understand, accept, and acknowledge the following terms:

- Payment for all services is my responsibility and is due and payable at the time services are rendered. **A current credit card will be kept on file.** The credit card number will be stored encrypted and used to cover account balances in accordance with the terms of this policy.
- Payment is due at the time of service. Any contract for insurance coverage is made between my employer, the insurance company, and myself. Gateway Pediatrics, LLC has no influence over available benefits or the approval of claims. I agree to pay for all charges for services rendered and/or materials furnished for this and any future visit(s).
- If Gateway Pediatrics, LLC is a participating provider at the time of service with my/my child's insurance company, Gateway Pediatrics, LLC will submit a claim to their insurance company. If Gateway Pediatrics, LLC is NOT a participating provider at the time of service, I am responsible for payment in full.
- Claims not paid within a timely manner (30 days) by my/my child's insurance company, become my immediate responsibility for payment in full.
- I will provide **all valid insurance information**, including primary and secondary insurance coverage. If a provider's name is required on the card as your Primary Care Physician (PCP), it must be the name of Gateway Pediatrics, LLC or its providers; if not, payment is my responsibility at the time of service.
- **Updates:** I am responsible for updating within fifteen (15) days any changes in regard to my phone number, address, expired/declined credit cards, and insurance information (including primary and secondary insurance) for myself/my child. Failure to update these does not absolve my responsibility for prompt payment.
- Any credit on my account will be a credit only and not refunded by Gateway Pediatrics, LLC unless requested in writing stating the amount due and the name/address of where to send the refunded payment. All written requests will be verified for accuracy and refunded within 30 days.
- **Non-Covered Services:** All health plans are not the same and do not cover the same services. In the event my health plan determines a service to be "not covered" I will be responsible for the complete charges. I understand payment is due at the end of the office visit or upon receipt of my/my child's insurance Explanation of Benefits (EOB). EOBs are sent to the insured prior to being sent to Gateway Pediatrics, LLC. Some insurers only send EOBs electronically. I will contact Gateway Pediatrics' Billing Department ASAP if I disagree with the information on the EOB.
- If I wish to use my/my child's insurance benefits to cover the cost of any ordered tests, procedures, or visits to third party providers it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers, and specialists. Payment for such services is my responsibility under the terms provided by said individuals. Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures, or visits to third-party providers are to be directed to my/my child's insurance carrier.
- **Well Child Visits / Physicals:** Periodic preventative health visits may or may not be covered under my health insurance policy, therefore, I will review my/my child's individual plan(s) for coverage information. Should one not be covered, and I desire for me/my child to have one, I will pay for the visit at the time of the service as a self-pay patient. If I have not checked with my insurer, or I did not disclose that the visit would not be covered, I will be responsible for payment in full.
- I will comply with maintaining my/my child's Well Child Visits / Physicals as per the American Academy of Pediatrics' Bright Futures Schedule for Well-Child visits or face dismissal from Gateway Pediatrics, LLC.
- **Personal Injury Cases:** I understand Gateway Pediatrics, LLC does not bill for auto accidents (aka "MVA" or "PIP" incidents) or other liability or lawsuit related cases (such as Worker's Compensation). I am responsible for payment in full at the time of service. I will submit my own claims. Gateway Pediatrics, LLC does not accept liens.
- **Minor Patients:** For all services rendered to minor patients, I understand that by signing this Financial Policy I am responsible for co-pays/deductibles/etc. and outstanding account balances at the time of service. I authorize use of my Credit Card on File for all balances and charges incurred if the child is brought in by another adult or if unaccompanied. I can choose to call Gateway Pediatrics, LLC prior to the appointment with alternate payment.
- I understand my account will be considered outstanding if balances are not paid within fourteen (14) days from the date from my/my child's insurer's EOB. A statement may be generated (with a $5 Statement Fee). Additional statements will incur additional Statement Fees.
- I hereby authorize **Gateway Pediatrics, LLC** to release any medical information concerning my/my child's illness and treatment deemed necessary to process this claim and any future claims to all insurers having responsibility for charges incurred. Additionally, I hereby assign all insurance benefits due me be paid to **Gateway Pediatrics, LLC**. For any amounts not paid by me, I direct all insurers pay directly to **Gateway Pediatrics, LLC** all such benefits. I understand that I am responsible for any amounts not covered by insurance. A copy of this signature is as valid as the original.
- **FEES:** Any statement generated will incur a **Statement Fee** of $5.00. (Effective 6/1/19). Returned checks unpaid by my financial institution will be subject to a **Returned Check Fee** of $35.00. An account is considered outstanding if not paid within thirty (30) days of the invoice/bill and may bear interest of 24% per annum (2% monthly).

COLLECTION POLICY & AGREEMENT

When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein may be sent to outside collection firms for legal collection action. It is understood and agreed to by the undersigned patient (or parent(s)/guardian or responsible party of minor child) that any account, which becomes more than ninety (90) days delinquent may be turned over to our attorney for initiating litigation to collect the outstanding invoice. If the undersigned fail(s) to make any payments due hereunder, Gateway Pediatrics, LLC may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise(s) to pay all cost of collection equal to thirty-five (35%), including, but not limited to, court costs, attorneys' fees equal to fifteen percent (15%) of any amount due and owing to Gateway Pediatrics, LLC, and any other collection fees which are incurred by or on behalf of Gateway Pediatrics, LLC in enforcing payment after default. If court action is necessary to enforce payment hereunder, the venue for any such court action shall be in Wicomico County, Maryland unless Gateway Pediatrics, LLC elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Payment Agreement shall be as valid as the original. Gateway Pediatrics, LLC will discharge (with 30 days' notice) the entire family of a guarantor sent to collections. Payment of the unpaid balance and cost of collection must be made in order for you/your child(ren) to return as a patient of our practice.

I have read and understand the financial policy of the practice and I agree to be bound by its terms for payment of all professional fees. By signing this statement, you and your designated parties have agreed that the insurance information you have provided to GATEWAY PEDIATRICS, LLC is the only health insurance coverage for the patient. I understand and agree that such terms may be amended by the practice. The patient/parent/adult signing below is ultimately responsible for all professional fees.

Signature of Parent/Guardian:_____ Date: _____

Print Name of Parent/Guardian:_____ SSN:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____

PATIENT NAME:_____ DOB:_____