DFW Pediatric Neurology

Dr. Mary Oladunni Baiyeri, MD, PA
1400 W. Northwest Hwy Suite 280 Grapevine, TX 76051
Tel: 817-416-8887 Fax: 817-416-8878

HEALTH FORM POLICY

DFW Pediatric Neurology charges $20.00 for forms and/or letters completed or certified by our physician. Before Submitting a form to your physician, please have your portion completed. Blank forms will not be accepted. We will not complete or certify a form if parents have not completed their portions of the form upon submission. A three-business day turnaround time is required for completion of forms. Requests for letters require a week turnaround time. Every effort will be made to complete forms as quickly as possible.

Forms and letters are completed for accounts that are in good standing. Delinquent accounts must be brought up to date. Forms and letters must be paid for before they are released. Parents are responsible for all charges associated with a Health Form/Letter completion. Insurance companies do not reimburse for the completion, therefore we do not bill them. This is a self-pay service.

Due to HIPPA regulations, forms will only be released to parents. Federal Law prohibits doctor's offices from faxing or mailing medical information to non-medical facilities. Forms must be picked up at the office by a parent or mailed to the home address on file. We cannot fax or e-mail a form to a school, camp, or sports organization. We cannot be responsible for delays or losses in the mail or fax.

OHI and seizure plans are forms that we do NOT charge for. Connor's, Vanderbilt, FMLA, Home Bound, and Medication for School and camp are forms that will be charged for, among others.

Patient's not seen within a year will need to be seen by the physician before completion of any form.

Patient Name:_____ DOB:_____

Parent Signature:_____D.O.B_____

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Financial/Office Polices

Patient Name:_____ D.O.B:_____

Payment: Payment is due at the time of service. If you have insurance, your copay, deductible, along with any co-insurance will be collected before seeing the physician.

Insurance: As one of your insurance companies' preferred providers, we require you first meet your copay, deductible, and/or any part that insurance does not pay, at the time of service. Most misunderstandings about insurance can be avoided if you understand what your policy provides. If your insurance chooses not to pay DFW Pediatric Neurology for whatever reason or they choose to delay payment, YOU will be responsible for payment. If payment is not received within 60 days from your insurance company, you will become responsible for the outstanding balance. Payment is expected at the time of service. Our office will assist you as our patient in filing your claims that we are contracted with and after obtaining all insurance information needed from you. We are not responsible for your insurance or for your bill.

Delinquent Accounts: Delinquent accounts will be reported to our collection service. Please let us know if your payment will be late in arriving to our office or if payment arrangements need to be made. Our desire is to help you.

Insurance Carriers Requiring Referrals (HMO.POS/EPO): If your insurance carrier requires you to have a referral prior to seeing a specialist, our office must be in receipt of the insurance referral before arrival. If we do not have it upon sign-in, your appointment will be rescheduled to a later date and time. Failure to obtain a referral can result in denial of charges, thus leaving the patient responsible for all services billed.

Late Arrivals: In order for the physician to see his/her patients in a timely manner, your help arriving promptly to scheduled appointments is required. We reserve the right to reschedule your appointment if you are more than **15** minutes late.

Cancellations/No Shows/Reschedules: There will be a $25.00 charge for patients who cancel, reschedule, or no-show an appointment without giving 24-hour notice.

Prolonged Physician Services: When a physician provides prolonged service beyond the usual and customary time frame, a separate charge will be billed to insurance. You will be responsible for any charges not covered by your insurance.

Telephone Services: If a telephone call between the physician and a patient/parent becomes excessive and medical advice is rendered, resulting in a telephone consultation, a separate charge will be billed to insurance. You will be responsible for any charges not covered by your insurance.

Prescriptions: There is a $10.00 charge for all triplicate (controlled drug) prescriptions given outside of a regular scheduled appointment. We do not charge this fee if the script is given at the time of the office visit. A refill approval can be withheld if the account is not in good standings. Prompt payment is appreciated. Our office requires a 48-hour notice when requesting any medication refill. No refills are approved after hours. You are required to call during office hours to request prescription refills. Keep in mind holidays and weekends.

Prior Authorization for prescriptions: There will be a $20 charge for prior authorization done by our office; if the medicine prescribed by the physician requires authorization through your insurance. We will bill this to each patient; unless you opt for a preferred drug on your insurance plan.

Returned Checks: There is a $30 charge for all returned checks. If a check is filed with the DA's office for collection, all fees incurred in the filing will be your responsibility as well. After a check has been returned twice for NSF, payments to our office must be on a cash basis only.

Out Patient Procedures Ordered: Patients are financially responsible for any out patient procedures ordered by their physician. Our office will assist in obtaining proper authorizations for the procedure prior to the date of service. You, the insured, are ultimately responsible for what your coverage requires and we suggest you contact your insurance carrier to verify your benefits prior to the date of service. Our office will not be responsible for your charges. DFW Pediatric Neurology charges a fee for interpreting any test that will be billed to your insurance that could result in payment beyond your office visit charge.

Disclaimer: You are informed by this notice that Mary Oladunni Baiyeri, MD, PA holds a financial interest in DFW Pediatric Neurology. You have the option, at your discretion, to use an alternate healthcare facility.

_____ _____

Patient or Parent/Guardian Signature Date

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Consent to Treat

I _____ (patient/parent name) give permission to DFW Pediatric Nuerology to give _____ (patient name) medical treatment.

I allow DFW Pediatric Neurology to file for insurance benefits to pay for the care I receive.

I understand that:

- DFW Pediatric Neurology will have to send my medical information to my insurance company.
- I must pay for my share of the costs
- I must pay for the cost of these services if my insurance does not pay of if I do not have insurance.

I also understand that:

- I have the right to refuse any procedure or treatment
- I have the right to discuss all medical treatments with my provider.

_____ _____

Patient or Legal Gaurdian Signature Date

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I hereby give DFW Pediatric Neurology the permission to display my child's artwork and/or picture in the office. I understand that at any time, I have the right to ask DFW Pediatric Neurology and Staff to remove the picture for any reason necessary.

_____

Patient's Name

_____ _____

Parent/Legal Guardian Signature Date

The selected photos/artwork are intended for the sole purpose of display at DFW Pediatric Neurology. They will not be shared, distributed, or sold to any outside intity. DFW Pediatric Neurology holds no liability when the above consent is agreed upon.

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CONTACT INFORMATION

I authorize DFW Pediatric Neurology and their agencies to contact me by the following medthod(s), Please check all that apply:

☐ Home #: _____

☐ Mom's Cell: _____

☐ Mom's Work: _____

☐ Mom's Email: _____

☐ Dad's Cell: _____

☐ Dad's Work: _____

☐ Dad's Email: _____

☐ Emergency Contact, when necessary: _____

☐ Ok to leave message with detailed information

☐ Leave message with call back number only

☐ I authorize DFW Pediatric Neurology and their agencies to disclose medical information, including by not limited to test results, reccomendations, and consultation details to the following person(s):

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Signature of Patient/Parent/Legal Guardian Date

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Patient Release of Medical Records Form

Patient's name: _____ Date of Birth: _____
Address: _____
Telephone #: _____ Alternate#: _____

Please release my medical records from:

Name of Provider: _____
Phone#: _____ Fax# _____
Providers Address: _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE TO DR. MARY BAIYERI, MD, PA.

_____ _____
Patient/Legal Guardian Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number _____

I acknowledge that DFW Pediatric Neurology provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient