Neponset Valley Pediatrics
Boston Children's
Primary Care Alliance

neponsetvalleypediatrics.com
781-784-0403 | *fax* 781-784-0407

Patient Policies

I. Health Information Portability and Accountability Act (HIPAA)

My signature below acknowledges I have received/read a copy of the practices Notice of Privacy Practices under HIPAA.

Signature of parent/guardian/patient:

_____

Relation to patient: _____Date: _____

II. Permission to share pharmacy and medical information

Neponset Valley Pediatrics may share information electronically with other healthcare providers involved in my child's medical care and behavioral health care. Information may be shared using platforms such as the Massachusetts Health Information Highway (Mass HIway), Massachusetts Immunization Information System (MIIS), Epic Care Link, Care Everywhere, and others. I agree that Neponset Valley Pediatrics can use these platforms to share my child's medical information. I have been provided with a copy of Neponset Valley Pediatrics notice of Privacy Practices that describes other uses and disclosures of health information.

My signature below acknowledges that I grant permission for the practice to obtain and review all medication information from any other medical entity (physician, hospital and/or pharmacy).

Signature of parent/guardian/patient:

_____

Relation to patient: _____Date: _____

III. Financial responsibility statement

Your health insurance many not pay for the item(s) or service(s) that you or your child(ren) will be receiving today and/or at future visits to this practice. Health insurers do not necessarily pay for all of your health care cost, they only pay for covered items and services according to your specific plan. The fact that insurance may not pay for a particular item or service does not mean you should not receive it if your doctor recommends it. The following is a partial list of services that may not be covered by your insurer:

- Non-covered vaccines
- Forms/Copies
- Co-payments
- Deductibles
- Travel advice visits
- Non–covered labs
- Co-insurance

If you are here for a well exam, please note the following:

Any issues, concerns, or illnesses that are outside the normal growth and development are automatically billed through our electronic medical record system.

Please be aware that this may incur a co-payment/deductible requirement with your insurance company.
This requirement is subject to your plan benefit design and **is not** controlled by our practice

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items and/or services, knowing that you may have to pay for them yourself. By signing below you agree to take the financial responsibility for the cost of all items and or services provided if you are not covered by your insurance. My signature below indicates that I accept financial responsibility for medical services not covered by my insurance plan.

Authorization

Signature of parent/guardian/patient:

_____

Relation to patient: _____Date: _____

Printed name of patient (child under 18):

_____