Gramercy Pediatrics
67 Irving Place • 3rd Floor, South • New York, NY 10003
420 West 23rd St. • Suite AGF • New York, NY 10011

Welcome to Gramercy Pediatrics! Thank you for your interest in our weight management practice. Before we begin our first visit, we would like to inform you of some important information.

- **Cancellation Policy:** We enforce a **$150** dollar cancellation policy for all weight management visits cancelled within **48 hours**. We understand that things do come up; however, to obtain the best results dedication is key.
- Each visit is between 30-45 minutes which is the allowable time per visit that the insurance company will reimburse for. Dr. Hes will see your child weekly to monthly depending on need.
- **First Visit:**
    - Due to the complex nature of pediatric obesity, Dr. Hes cannot cover all issues during the first session.
        - **What to Expect:**
            - Dr. Hes will get to know your child and understand the basic background that led to this point.
            - She will order blood tests based on her evaluation (bloodwork must be fasting, no eating after midnight). This will be done after the initial visit.
            - If your doctor has already drawn labs, please have the results forwarded to our office prior to the initial visit.
- **Subsequent visits:**
    - These visits will cover different issues related to your child's health.
        - **Topics to be discussed:**
            - Basic Nutrition
            - Exercise
            - Appetite
            - Child's Schedule/sleep
            - Feeding Patterns
            - Emotional eating
            - Child's overall behavior
            - Family Dynamics

Dr. Hes' treatment is not only "medical" but also includes motivational interviewing and readiness for change. Dr. Hes does not use meal plans but will make recommendations catered to each child's needs.

By signing this patient/physician agreement you are verifying that you are agreeable to our cancellation policy and understand what to expect during your child's weight management visits.

_____ _____

Responsible Party Signature Date

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Patient's name: _____ Birth Date: _____

Age: _____ Sex: M F

Address: _____

Phone (Primary): _____

Phone (Secondary): _____

Email: _____

Insurance Information

(*Please give your ID and insurance card to the receptionist***)**

Is patient covered under both parent's insurance? Yes? No?

Insurance Carrier (circle one): Anthem/Empire Cigna Aetna Self-Pay

Insurance Policy Number: _____ Group Number: _____

Name of Responsible Party: _____ Date of Birth: _____

Address (if other): _____

Phone: _____ Relationship to Patient: _____

HIPAA/Prescription Consent Form

I give Gramercy Pediatrics, LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, to view any past prescription histories, and for health care operations like quality review.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

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Vaccine Policy Statement

The effectiveness of vaccines to prevent serious illness and to save lives has been proven beyond any doubt. For this reason, all children and young adults should receive the vaccines recommended by the Centers for Disease Control and the American Academy of Pediatrics. Vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedules are the result of years of scientific study. Because we are committed to protecting the health of your children through vaccination, we require all of our patients to be vaccinated.

As medical professionals and your trusted partners in the care of your children, we feel strongly that vaccinating on schedule with currently available vaccines is the right thing to do for all children and young adults. By not vaccinating, you are putting your child and other children at unnecessary risk for life-threatening illness and disability, and even death. Thank you for your time in reading this policy. Please feel free to discuss any questions or concerns you may have with any of the providers.

If you should decide not to vaccinate your child despite all our efforts, we request that you find another health care provider who shares your views.

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Dyan S. Hes, Gramercy Pediatrics, LLC for medical services rendered to my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Dyan S. Hes, Gramercy Pediatrics, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

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I have requested medical services from Dr. Dyan S. Hes, Gramercy Pediatrics, LLC on behalf of my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Office Policy on Insurances and Payments

As a courtesy to you; our office participates with several insurance carriers. Please familiarize yourself with your insurance's practices and policies.

1. You will be asked to leave a credit card number at the time of check in. This information will be held securely until your insurances have paid their portion and notifies us of your share.
2. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. copays), we are legally required to collect these and no exceptions will be made. All copays and balances are due at the time of your visit. You are responsible for all balances on your account not paid by your insurance carrier. If you or your insurance carrier fail to pay your bill, for any reason, for more than 90 days past due, we reserve the right to bill your credit card for any outstanding balances. Outstanding balances over 90 days past due will be sent to a collection agency for payment. All accounts sent to a collection agency will be assessed a surcharge of 50% of the balance due to cove the collection costs.
3. If your insurance requires you to meet an annual deductible before your health care is covered, you will be billed for the services rendered if you have not met your deductible.
4. **After hours, prolonged telephone encounters (greater than 5 minutes) or those that lead to a pharmacy or hospital call will be billed as telemedicine visits as per ACA guidelines. This may result in an additional charge in the form of a copay or may be applied towards your deductible. Please contact your insurance company for more information.**

I, _____ (print name) authorize Gramercy Pediatrics, LLC to charge **outstanding balances/cancellation and no show fees** to the following credit card(s):

Card Issuer:	**Card Number:**	**Expiration Date:**	**Security Code:**	**Zip:**

Name on Card: _____ **Signature:** _____

Email: _____

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Office Policies

- **Lab Fee**:
  - We feel that having a laboratory in the office is imperative to providing the highest level of care for your children. In order to maintain the operation of this laboratory, there will be an additional **$25-$30** fee for the on-site blood draw, which is not covered by insurance. If you do not wish to pay this fee, you have the option to go to an outside lab that is approved by your insurance company.

- **Cancellation Policy**:
  - Non-Routine(Sick) Appointments:
    - If your child cannot make the scheduled appointment time, you must notify the office **24 hours prior** to the scheduled appointment. If we are not notified **24 hours prior** to the appointment, there will be a $**75.00** cancellation fee per child/per non-routine appointment**.**
  - Routine Well Visit/Annual Visit Appointments:
    - If your child cannot make the scheduled appointment time, you must notify the office **24 hours prior** to the scheduled appointment. If we are not notified **24 hours prior** to the appointment, there will be a $**150.00** cancellation fee per child/per non-routine appointment**.**
  - Scheduled Weight Management Appointments:
    - If your child cannot make the scheduled appointment time, you must notify the office **48 hours prior** to the scheduled appointment. If we are not notified **48 hours prior** to the appointment, there will be a $**150.00** cancellation fee per child/per non-routine appointment**.**
- **Forms**:
  - Due to an increased demand for health forms, our new form policy is as follows:
    - **All forms require 7-10 business days to process**
  - $15 for NYC universal health forms
  - $30 for non-universal health forms
  - $50 for any form needed sooner than 7 business days
  - $0.75/page for medical records released to a parent ***(Free to send to another pediatrician)***

Please note: ***In order to meet HIPAA compliance, the file must be encrypted with a password (your child's date of birth in the format, MM/DD/YYYY, with the slashes)***

Responsible Party Signature **Date**

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Late/Missed/Cancelled Appointment Policy

Gramercy Pediatrics is growing which is great news. With this growth it is very important for each family to make sure they arrive to their appointment on time. We do NOT double book which means when you make an appointment with us, we reserve this time for you and your child. If you follow the instructions for the Healow app you will receive an appointment reminder. However, it is YOUR responsibility to remember your appointment.

UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE IT IS OUR POLICY TO CHARGE **A missed appointment FEE**.

$75 for sick or follow up visits

$150 for well visits/school, camp physicals

Weight Management appointments (for obesity & nutrition consultations with Dr. Hes) require **48 HOUR** CANCELLATION NOTIFICATION. These appointments are limited and last 45 min- 1 hour.

The purpose of this policy is not to penalize you, but to make sure that you and all of our patients are seen on time. If you arrive more than 15 minutes late for your scheduled appointment it will be considered a missed appointment as it will run into another patient's scheduled appointment time. If you fail to show up, or are more than 15 minutes late, you have not only wasted your appointment and our time but you have taken away the opportunity for us to see other patients who could have been seen at that time, had you cancelled or rescheduled your appointment in advance.

I have read and agree to the terms of this financial policy.

_____ _____

Responsible Party Signature **Date**

_____

Patient Name

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Delegation of Consent

Name of Patient: _____ DOB: _____
(Date of Birth)

I hereby authorize (when I am unavailable to give consent) the following individuals(s):

_____ _____
Name of Person Relationship to Child

_____ _____
Name of Person Relationship to Child

_____ _____
Name of Person Relationship to Child

_____ _____
Name of Person Relationship to Child

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of New York. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

_____ _____ _____
Responsible Party Signature **Relation to Patient** **Date**