Jacqueline A. Krohn, MD, MPH
3917 West Road, Ste. 136, Los Alamos, NM 87544
Phone: (505) 662-9620, Fax: (505) 662-0024

Financial Policy

Payment for services is due on the day of your appointment. We accept cash, personal check, and Visa, Mastercard, or Discover card.

Insurance
Because of patient privacy laws (HIPPA) your insurance company cannot release your information to us. Therefore, we cannot call them to obtain the information found on your card. Only you can give us this information.

At this time our office files insurance for all pediatric patients unless you specifically request we do not. By law, only the physician's office can file for Medicaid.

Should you be confused regarding filing insurance, the Insurance Supervisor will be glad to answer any questions you may have. The Insurance Supervisor cannot, however, be expected to know what your insurance will pay. Payment is determined by the insurance company upon receipt of the claim.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

As of 12/14/2010 there will be an added charge for all emergency appointments. Your insurance may not cover this charge, leaving you responsible for payment.

Referrals and Preauthorizations
If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Medicare
Dr. Krohn has opted out of the Medicare program and does not file claims to Medicare, or Medicare replacement insurances.

Dr. Krohn does not accept any new Medicare patients or adult Medicaid patients.

Missed Appointments
We require at least 24 hours notice if you are unable to keep your appointment. Failure to provide notice may result in a $25.00 fee that will be placed on your account and billed to you. This fee is not covered by insurance and you will bear complete financial responsibility for this fee. For CHIP and WDI Medicaid, a fee up to $5.00 may be charges to your account. For all other Medicaid, three missed appointments may result the patient being dismissed from this practice.

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, Visa, Mastercard, or, Discovercard. Post-dated checks will be accepted only if they are dated at most within a week of the appointment.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Returned Checks
A $25.00 charge will be applied for returned checks. The charge will be payable by cash, or money order. You may be placed on a cash only basis following the return of a check.

Workers' Compensation and Automobile Accidents
In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent three statements. If payment is not

made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

All financial arrangements are to be made with the front desk. Dr. Krohn does not discuss finances nor do any other staff members.

If you are unable to pay your bill on time, please discuss it with the front desk and we will do our best to work out a payment plan with you. However, regular monthly payments will be required.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal or legal arrangements that a patient might have outside of our office, if you are over 18 years of age, receiving treatment, and insurance does not cover the service, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

In case of divorce or separation, the parent or guardian who brings the child in for treatments is responsible for the copayments, uncovered amounts, or the total bill for the day if there is no insurance. Documentation needed for proof of payment will be provided.

Patient, parent, or guardian signature   Date

__________________________________   _______________

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Patient Information

Date____________________________Date of Birth__________________MR#_________

Patient's Legal Name____
First   Middle   Last

Preferred Name____

Street Address____
City____State______________Zip__________
Drug Allergies_________________________________Sex_______SSN_______________
Marital Status(S)_______(M)________(D)_________(W)___________(Sep)_________
Employer's Name and Address____
Phone (H)_________________Phone(W)___________________Phone (C)__________
City____State_________Zip_________

Spouse Or Parent Information

Mother's Name____

(Responsibility Party) ____(Y) ____(N) Mother's Maiden Name___________________

Street Address____
City____State________Zip_________
Employer's Name and Address____
City____State________Zip_________
Phone (H)_________________Phone(W)___________________Phone (C)__________
SSN____

Father's Name____

(Responsibility Party) _____(Y) _____(N)

Street Address____
Employer's Name and Address____
City____State_________Zip_______
Phone (H)________________Phone(W)____________________Phone (C)__________
SSN____

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Billing Information

Person Responsible for Payment____

Street Address____
City_________________________________ State___________________ Zip__________
(H) Phone___________________ (W) Phone_________________ (C) Phone___________

Insurance Information

Date ________________ DOB__________________

Patient's Legal Name____
First Middle Last

(PRIMARY)
Name and Address of Company____
City________________________________State___________________Zip_____________
Insured's Name____________________________Effective Date of Coverage___________
Group # ___________________________ Policy ID # ______________________________

(SECONDARY)
Name and Address of Company____
City________________________________State___________________Zip_____________
Insured's Name____________________________Effective Date of Coverage___________
Group # ___________________________ Policy ID # ______________________________

Our office will file some primary insurances (not secondaries), please ask. Please remember you are responsible for all fees at time of service, regardless of insurance coverage.

Signature of Patient or Legal Guardian ____
Date_____________________

I authorize the release of any medical information necessary to process this claim.

Signed_________________________
Date___________________________

I authorize the release of medical benefits to Dr. Krohn.

Signed_________________________
Date___________________________

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

Dr. Jacqueline Krohn
3917 West Road, Suite 136, Los Alamos, NM 87544
Phone: (505) 662-9620
Fax: (505) 662-0024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

HIPAA

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

HIPAA

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

LOS ALAMOS PEDIATRIC CLINIC

Acknowledgement of Receipt of Privacy Policy

I have been presented with a copy of this practice's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

____
____
____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: ______________________________
Date: ______________________________
Patient Name (Please Print): ______________________________

If not signed by patient, please indicate relationship to patient.

Relationship: ______________________________________

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[] Individual refused to sign

[] Communication barriers prohibited obtaining the acknowledgement

[] An emergency situation prevented us from obtaining acknowledgement

[] Other (please specify)

____
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LOS ALAMOS PEDIATRIC CLINIC

CONSENT TO PERFORM MEDICAL SERVICES

1. I hereby authorize and direct the physician and staff of Los Alamos Pediatric Clinic to perform the following services including the use of any necessary or advisable local anesthesia or laboratory tests.
   - Medical exam and treatment
   - Allergy testing
   - Casting, minor surgery, laceration repair, or drainage of abscess
   - Wart treatment

2. I understand that there are risks involved in this in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desire able to the health and well being in the professional judgment of the physician or allergy technician.

4. I will be advised that the success of the medical treatment to be provided will require that the patient and the parents follow the post care instructions of the physician or allergy technician. I agree that the success of the treatment requires that all post care instructions are followed and that regular office visits as scheduled by my physician and her auxiliaries must be maintained.

5. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

6. I further understand that this consent will remain in effect until such time that I choose to terminate it.

DATE: ____________________ TIME: __________________ AM/PM
Patient Name: ____
Name of Parent or Guardian: ____
Relationship to Patient: ____

Signature: ____

Disclosure of Protected Health Information Log

Date	Time	Name of Requestor (include business info.)	Reason for Request	Info. Requested* (BE SPECIFIC)	Known?	Approved by/date (if applicable)	ID of Sender/date
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		
					YES **NO**		

Note: If the request is for a patient's entire medical record, you must document a reason why.