Date:
Total Cost of Plan(s):

Decatur Pediatric Group Children's Health Plan

Guarantor Name	☐ M ☐ F		DOB:
Address			
City	State	Zip	Email Address:
Home #	Cell #		

FAMILY INFORMATION

CHILDREN'S NAMES	DATE OF BIRTH	SEX
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F

HOW DID YOU HEAR ABOUT US?

INTRODUCTION

Welcome and thank you for your interest in Decatur Pediatric Group's Children's Health Plan.
At Decatur Pediatric Group your child's health is our primary concern. Decatur Pediatric Group recognizes that many families may have lost or have limited health care insurance. In these difficult situations, we are pleased to offer our Children's Health Plan.
Please e-mail us with questions at chp@decpedgrp.com

The CHP program may not be used with insurance plans that pay 60% or higher.
The CHP program is not an insurance plan and shall not be in any way interpreted as such.

$15.00 co-pay per member per visit

MEMBERSHIP BENEFITS

COVERED SERVICES

Well Examination Office Visits
Recheck/Follow-up Office Visits
Sick Office Visits
Sports Physicals
Immunizations
Hearing Screening Test (with WELL EXAM ONLY)
Vision Screening Test (with WELL EXAM ONLY)
Hemoglobin Test (9 months-18 years of age with WELL EXAM ONLY)
Flu Shots
Flu Mist
Urinalysis (3 years-18 years of age with WELL EXAM ONLY)
After-Hours Phone Calls (up to 3 per plan year)

FORMS INCLUDED WITH WELL EXAM

Administration of Medicine Form for Daycares and Schools
GA Form 3300-Hearing, Vision, and Dental Form
GA Form 3231-Immunzation
Pre-participation Physical Evaluation Form (Sports Clearance)

SERVICES NOT COVERED

Specialist Care
Medications or Prescriptions
Any labs (e.g. blood test, PKU, etc)
Ear Piercings
Asthma Breathing Treatments and Supplies (e.g. medications, mask, tubing, nebulizers)
Any additional procedures not listed under well exam
Any lab tests or screening tests repeated or conducted without a Well Exam.

DIAGNOSTIC TESTING NOT COVERED

Rapid Strep Test
Urine Culture
Pregnancy Test
Cholesterol & Lipid Panel
Complete Metabolic Panel

SELECT A PLAN

□ **NEWBORN- 1 YEAR PLAN**
□ **2 YEAR PLAN**
□ **3 YEAR PLAN**
□ **4 YEAR PLAN**
□ **5 YEAR PLAN**
□ **6 YEAR PLAN**
□ **7 YEAR PLAN**
□ **8 YEAR PLAN**
□ **9 YEAR PLAN**
□ **10 YEAR PLAN**
□ **11 YEAR PLAN**
□ **12 YEAR PLAN**
□ **13 YEAR PLAN**
□ **14 YEAR PLAN**
□ **15 YEAR PLAN**
□ **16 YEAR PLAN**
□ **17 YEAR PLAN**
□ **18 YEAR PLAN**

Each Plan Includes:

Well Examination Office Visits
Recheck/Follow-up Office Visits
Sick Office Visits
Age Appropriate Vaccines and Flu Shots/Flu Mist
Hearing and Vision Screening and 3300-Hearing, Vision, and Dental Form with Well Exam visit (3 years-18 years only)
Hemoglobin Test (yearly) and Urinalysis Test (yearly) with Well Exam visit (3 years-18 years only)
Sports Physical and Pre-participation Physical Evaluation Form (Sports Clearance) (6 years-18 years only)
GA 3231 immunization record forms with each Well Exam visit
Administration of Medicine Form for Daycare and Schools
After-Hours Phone calls (up to 3 per plan year)

Services cannot be substituted. $15.00 co-pay applies per office visit.

TOTAL AMOUNT $_____

DECATUR PEDIATRIC GROUP, P.A.
CHILDREN'S HEALTH PLAN CONTRACT

This agreement is made this_____day of_____, 20_____ by and between

_____ (Guarantor) for _____ (Patient)

(hereinafter referred to "CHP"-Patient) and Decatur Pediatric Group, P.A.

PURPOSE AND INTENT

The sole purpose and intent of this agreement is to provide an economical way to pay for medical services. This program is not an insurance plan and should not be interpreted as such.

Decatur Pediatric Group, P.A. agrees to provide primary care physician services (medical care) and annual prepaid office visits for the CHP-Patient, except when certain procedures are not covered, which will then be the responsibility of the patient/guarantor. All office visits require a $10.00 per patient co-payment, in addition to the total plan amount.

The Guarantor represents that they are over the age of eighteen years and desire to enter into this agreement. Further, this agreement represents that the Guarantor is respectively capable of fulfilling their payment obligations to Decatur Pediatric Group, P.A. By signing this Guarantor agrees to fulfill all payment obligations of this plan agreement.

Decatur Pediatric Group, P.A. makes no misrepresentations as to our ability to permanently cure any conditions or ailments. We will, however, do everything we feel medically necessary to diagnose and treat any and all illnesses. We also recognize that some illnesses may require further treatments in hospitals or with specialists (secondary/tertiary).

These secondary and tertiary services are not covered under the Children's Health Plan. However, Decatur Pediatric Group, P.A. will arrange for these services by referring patients to specialists and/or admission to hospitals.

The CHP program may not be used with insurance plans that pay 60% or higher.
The CHP program is not an insurance plan and shall not be in any way interpreted as such.

SELECTION OF PHYSICIANS

Decatur Pediatric Group, P.A. certifies that all patients will be seen by a Board Certified Medical Provider to examine and prescribe necessary treatments and medications.
Guarantors may select the preferred provider of their choice, within Decatur Pediatric Group.

TERMINATION

At the discretion of the Guarantor or Decatur Pediatric Group, P.A, this agreement may be terminated by providing a written notice of termination. In the event of early termination, the Guarantor will be responsible for Decatur Pediatric Group's cost incurred up to the date of termination. All office visits and medical procedures will be tabulated and any outstanding balances will be due upon termination of this agreement. Guarantor expressly understands that refunds or credits cannot be administered for any early termination of this agreement

SIGNATURES

This agreement shall insure to the benefit of and be binding on the parties, their heirs, personal representatives, successors and assigns. In WITNESS WHEREOF, the parties have executed this agreement on the date first written below.

Dated this_____day of_____, 20_____

_____ Guarantor's Signature

_____ Practice Representative's Signature

_____ Guarantor's Printed Name

_____ Practice Representative's Printed Name

The CHP program may not be used with insurance plans that pay 60% or higher.
The CHP program is not an insurance plan and shall not be in any way interpreted as such.

CHILDREN'S HEALTH PLAN
INSTALLMENT PAYMENT AUTHORIZATION

- *This plan may be paid in full upon enrollment or in monthly installments.*
- *Plans paid in full will receive a 10% discount; monthly installments incur 5% monthly service fee.*
- *Monthly installments may be made by check or credit card.*

INITIAL PAYMENT $_____ (MUST BE MINIMUM OF 40% OF TOTAL PLAN COST)

NUMBER OF INSTALLMENT PAYMENTS_____ (WILL INCUR ADDITIONAL SERVICE FEE OF 5% PER MONTH)

MONTHLY AMOUNT TO BE CHARGED FOR INSTALLMENT PAYMENT $_____

DATE INSTALLMENTS PAYMENTS WILL BEGIN _____20___

PAYMENTS BY CHECK

NAME (as it appears on check) _____

CHECKING #_____ ROUTING #_____

I HEREBY AUTHORIZE DECATUR PEDIATRIC GROUP TO DEBIT MY ACCOUNT FOR THE AGREED UPON MONTHLY INSTALLMENT PAYMENTS FOR THE CHILDREN'S HEALTH PLAN.

ACCOUNT HOLDER'S SIGNATURE_____ DATE_____

PAYMENTS BY CREDIT CARD

CARDHOLDER'S NAME (as it appears on card) _____

CARDHOLDER'S BILLING ADDRESS _____

_____

CARD NUMBER_____ EXPIRATION DATE_____

3 DIGIT CVV # (located on back of card)_____

I HEREBY AUTHORIZE DECATUR PEDIATRIC GROUP TO CHARGE MY CREDIT CARD FOR THE AGREED UPON MONTHLY INSTALLMENT PAYMENTS FOR THE CHILDREN'S HEALTH PLAN.

CARDHOLDER'S SIGNATURE_____ DATE_____