Pediatric Associates

Office Policy

Appointments

1) We value the time we have set aside to see and treat your child. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) If you are not able to keep an appointment we would appreciate 24 hour notice. We reserve the right to charge $35.00 for repeatedly missing scheduled appointments without notifying our office.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a preventative (well-child) visit.
5) During your appointment if you receive both Preventative (well) Care and are also treated for an illness you will incur two separate charges.

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance information you designate is incorrect, you will be responsible for a $25.00 reprocessing fee.**
2) If your insurance company requires a primary care physician, make sure our physician's name appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
    b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
    c. For children over the age of 2, most insurance companies allow only one well visit per year.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service. A **$25.00 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **21** business days of your receipt of your bill.

6) If previous arrangements have *not* been made with our billing office, any account balance outstanding longer than 90 days will be forwarded to a collection agency. A processing fee of $25.00 for each child's account will be added to the balance.
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
9) We accept cash, checks, Visa, and MasterCard credit and debit.
10) A $35.00 fee will be charged for any checks returned for insufficient funds.

Forms

1) There is no charge for vaccination records given at the time of your child's visit. This is considered part of the visit. **However,** should you lose your record; there will be a $5.00 charge to replace them.

Transfer of Records

1) We require 48 hours' notice.
2) A copy of your complete record is available for a $.60-per-page fee.
3) We provide records of your child for visits (including consultations from specialists) rendered here at Pediatric Associates. For any previous records, you must request them directly from your previous doctor(s).

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. Either I or my insurance company may revoke this authorization at any time in writing.

I AUTHORIZE THE doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my child. I understand that this medical information will only be used for the following purposes: diagnostic, referring physician, or insurance. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without authorization signed by me for release of the information.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name_____

Responsible Party's Name _____**Relationship**_____

Responsible Party's Signature _____ **Date** _____

On completion, we will provide you with a copy for your records.

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