

Office Policy

- We are committed to providing you with the best possible medical care in a timely manner and in a warm, patient-friendly environment. Our office policies are designed to help us reach this goal. We are available to discuss these policies with you should you have any questions. As a courtesy to our families, we will file your insurance, but we cannot know the particulars of what each individual policy covers. We are here to offer comprehensive medical care for your children. Please be aware that not all our services may be covered by your insurance, and you will be responsible for these charges.
- We accept all major credit cards, checks, and cash.
- Copays and Deductible amounts are required at the time of service. If there is a problem with your insurance or there are extenuating circumstances that make impossible for you to pay at your visit, you must call and speak with our billing specialist before your appointment. If you have a balance, you MUST speak with our billing specialist before your appointment so that payment issues can be resolved prior to your visit.
- Minors must be accompanied by an authorized adult. The authorized adult accompanying your child is responsible for payment when services are rendered. Financial responsibility due to divorce settlements (or other legal situations), is to be worked out between parents prior to arrival and will not be discussed in our office. If your child is old enough to come to our office on his/her own, you are to make sure that he/she comes with appropriate funds needed to cover out of pocket expenses, and has current health insurance card.
- Insurance cards must be present at each visit for every patient. If you are unable to provide your current insurance card at the time of service, you may be required to pay for that visit, or reschedule your appointment. It is your responsibility to know the guidelines of your plan. Your insurance policy is a contract between you and your insurance provider. We will NOT become involved in disputes between you and your insurance company. You are responsible for the timely payment of your account, whether it be a patient balance or an insurance balance.
- If you are unable to make it to your scheduled appointment, it is your responsibility to notify our office, during regular office hours, within 24 hours, of the scheduled appointment; failure to do so will result in a \$50 no-show charge for well/sick appointments and \$75 for consults. Your insurance does not cover this charge. Leaving a message or the call voicemail does not cancel your appointment and will not be honored.

FINANCIAL RESPONSIBILITIES

1. Who should receive the billing statements: _____

Relationship to patient: _____

2. According to ALL insurance plans, you are responsible for any and all copayments, deductibles and coinsurance at the time of service.
3. Because of the complexity of the insurance payment system, if you have a deductible, you are responsible for \$100 or any type visit at time of service and we will submit the claim to your insurance company and bill you for the remainder.
4. Self-pay patients, or patients who file their own insurance are expected to pay for services in FULL at the time of service.
5. If your account is turned over to a collection agency, there will be a \$30 collection fee added to your balance.

INSURANCE PLANS

1. Even with the best technology and access to many different insurance verification sites, we may not be able to keep your insurance plan correct without your help. We need to have updated insurance information as soon as you know there is a change, even if your child is not due to come see us for several months.
2. It is your responsibility to understand your child's benefit plan, and what services are covered, what hospitals and labs are covered. In pediatrics this is somewhat streamlined but not all plans cover annual well physicals, sports physicals, or hearing and vision screening. If these are not covered services, you will be responsible for payment.
3. 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.

REFERRALS

1. All non-emergency referrals typically take 3-5 business days.
2. It is your responsibility to know if a selected specialist participates in your plan.
3. We cannot obtain referrals if you go to an urgent care or walk in clinic. Your child will need to be seen in our office prior to any referrals being made.

APPOINTMENTS

1. Appointments for additional children should be made by phone prior to coming to the office.
2. If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. Dr. Mary requires all patients have annual well visits, sports physicals are not considered well visits.

FORMS

1. There is no charge for a blue and yellow form, sports physical or camp forms requested at the time of your child's well visit appointment. If the forms are needed outside of the schedule appointment, there will be a \$10 charge. There is a 3-5 business day turnaround time, if forms are needed within 24 hours, an additional \$10 rush fee will apply.
2. Family and Medical Leave Act forms are \$40. Payment is due when forms are dropped off. We require a 7-10 business day turnaround time.
3. All forms are requested to be paid as cash or check only, except rush request.

PRESCRIPTION REFILLS

1. Please call our office, not your pharmacy, to request any medication refills. We do require a 7-10 business notice for all refills. If you are out of medication and need a refill within 24 hours, please note that \$10 rush fee will apply.

I have fully read and understand this office policy in its entirety.

Name (Print): _____

Date: _____ **Relationship to Patient:** _____

Signature: _____