KIDS HEALTH ALLIANCE, PA

Office Policy (*Rev 2/12/2014*)

Patient name: ***DOB:***

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully* . If you have any questions, do not hesitate to ask a member of our team.

Appointments:

1) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment we would appreciate 24-hour notice. **There is a charge of $ 25 for missed appointments or not canceled appointments within 24 hours.**

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) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

4) It can be to your advantage to occasionally be seen by another provider from our group. This allows a provider with a different perspective or area of expertise to participate in your child's care. We will make every effort for you to see the provider of your choice but under certain circumstances it cannot be possible. We strive to provide the quickest, quality service with minimal wait time. Thank you for your understanding and courtesy to our providers and medical team members.

5) You can see our providers at any of our 3 locations (SW ,SE or Dunnellon office) that is convenient for you. Please mention about your choice during appointment scheduling.

Insurance Plans:

1) If you are covered by a commercial insurance plan that we accept, we will file a claim to your carrier. You will be expected to pay any co-pay, co-insurance, non-covered services, and or any deductibles at the time of service. A **$10 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.

2) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit.

3) 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.

4) If you have an HMO plan please make sure that we are listed as the primary care physician on the card. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.

5) 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.

6) It is your responsibility to know if a written referral or authorization is required to see specialists, and whether preauthorization is required prior to a procedure, and what services are covered.

Financial Responsibility:

1) Self-pay patients are expected to pay for services in FULL at the time of the visit. We offer a discounted sliding scale rates for patients without insurance.

2) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

3) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.

4) If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a **$5 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency and a fee will be charged.

5) For scheduled appointments, prior balances must be paid prior to the visit.

6) 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.

7) We accept cash, Visa and Master Card, credit and debit, checks with a copy of valid driver's license.

8) A **$30** fee will be charged for any checks returned for insufficient funds and payment is expected within 7 days or it will be turned over to the District Attorney's office.

Well visits and immunization:

1) We follow AAP (and your insurance company) guidelines for age specific well visits and it's required that you bring your child for well visits irrespective of whether you want to immunize your child or not. ***Frequent missing of well visits may lead to discharge from our practice***.
2) We strongly recommend immunization of your children but we do not discharge if you choose not to immunize your child. You assume all risks associated with non-immunization.
3) You are required to sign a vaccine refusal form each time you refuse to vaccinate your child .
4) If you follow an alternative immunization schedule it's your responsibility to let us know which vaccine you want during any given visit.

School Excuse:

1) Excuses are given for the days when patient is seen or if authorized by MD to keep the child home for certain days.
2) If MD was not informed about child's continual sickness and school absences due to it , MD cannot give any excuse retroactively for keeping the child home for extended period .

Forms:

1) Forms are completed for those whose accounts are in good standing. Delinquent accounts must be brought current before forms will be released. Forms must be paid for before they are released.
2) Blank forms will not be accepted.
3) There is no charge for blue or yellow form given at the time of your child's visit. This is considered part of the visit. However, should you lose your form, there will be a **$1** charge per form to replace them.
4) Any additional school, camp, or sport forms are subject to a **$5** per form fee.
5) We require a **48** hour turn around time.
6) Payment is due when the forms are dropped off.

Transfer of Records:

1) If you transfer to another physician, we will provide a copy of your immunization record and your last physical to your physician, free of charge, as a courtesy to you. We need **48** hour notice.
2) A copy of your complete record is available for a **$1** per-page fee for the first 25 pages and **0.25** cents per page thereafter once HIPPA form is signed.
3) We only provide copies of records (including consultations from specialists) rendered here at Premier Pediatrics, LLC. For any previous records, you must request them directly from your previous doctor(s).

Referrals:

1) Referrals are done only after patient has been seen in our office for the condition the referral is being sought.

Prescription Refills :

1) ADHD stimulant medication refills are done only during monthly visits. They can't be called in, faxed or e-prescribed. Lost prescriptions are not filled until due time.
2) If we prescribe any schedule II control substances we may request random pill count ,urine drug screening to ensure compliance and to rule out medication diversion and illicit substance use.
3) We generally do not prescribe narcotic pain medications or controlled anxiety medications.
4) All other maintenance medications (i.e. asthma, allergies, and bedwetting e.t.c) are refilled only if child has been seen within 3 months. If not, an appointment is needed before refills are done .
5) No antibiotics are prescribed or refilled without a patient evaluation in our office.

Policy on gun counseling:

AAP recommends counseling parents on fire arm safe storage practices. We agree with this policy and recommend the same. Due to recent controversies on this issue we will not individually ask about gun ownership and counsel about it. Parents are to follow safety guidelines and provide a safe home for their children.

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(s) _____ DOB:_____

Responsible Party Member's Name:_____Relationship_____

Signature: _____ ____Date_____ _____