CHILDPlus
PEDIATRIC HEALTH & WELLNESS

Office Policy for Patients

Our goal of this document is to provide and maintain a good physician-patient relationship. Keeping our patients informed of our office policy allows for the responsibilities to be clearly defined. It is our goal to provide clear communication thus enabling us to achieve our mutual goals. ***Please read each section carefully and initial.*** **If you have any questions, do not hesitate to ask a member of our staff.**

Appointments

1) In the interest of making ourselves available we have provided our patients with a Patient Portal which can be accessed from our website (www.ChildPlusPediatrics.com) whereby you can request an appointment that meets your busy schedule. Our staff will contact you and confirm your request within 12 hours, or recommend other times based on Doctor(s) availability. You may also contact the office directly to request an appointment.
2) **You are responsible for paying your co-pay or meeting any outstanding deductible before seeing the doctor, based on anticipated medical services to be delivered.**
3) 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 a 24-hour notice. If we do NOT hear from you **there is a charge of $50 for missed appointments.**
4) 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.
5) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
6) Before making an annual physical appointment, or well check appointments, we would request that you check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit. Different Insurance plans have specific guidelines on these types of visits and we would encourage you to become familiar with your specific coverage.

Initial: __________

Insurance Plans

Please understand

1) It is your responsibility to keep our front desk staff informed of your correct insurance information. **If the insurance company you designate is incorrect, or if medical services delivered fall outside of your coverage parameters you will be responsible for payment, or you will be provided with the documentation of the visit and charges so that you can submit it to the correct plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number 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 coverage's, 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.
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.

Initial: __________

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued.

Initial: ___________**turn over**

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.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit. Please ask about our discounted cash payment fees for those clients without insurance.
4) 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.
5) 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.
6) Any balance outstanding longer than 90 days will be forwarded to a collection agency.
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) We also provide our parents with the opportunity to pay their outstanding balances online by using the Patient Portal located on web site. You must complete your online registration to use the site before payments will be accepted.

Initial: ___________

Forms

1) Any additional school, camp, or sports forms are subject to a $10-per-form fee. Family and Medical Leave Act forms are $10. Payment is due when the forms are dropped off. We may require up to a 3-day turnaround time.

Initial: _____________

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2) A copy of your complete record is available for a $1-per-page fee (up to a max of $50.00).
3) We provide records of your child for visits (including consultations from specialists) rendered here at Child Plus Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____________

Prescription Refills

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

Initial: _____________

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)____

Responsible Party Member's Name ________________________**Relationship**_____________

Responsible Party Member's Signature ______________________ **Date** _________________

Upon completion and upon request, we will provide you with a copy for your records.