

Peds In A Pod Pediatrics, LLC

Office Policy

We appreciate you for choosing Peds In A Pod Pediatrics, LLC as your child's medical home. Our goal is to provide and maintain a good physician-patient relationship. As one of our patients, we would like to inform you in advance of our office policy which allows for good flow of communication and enables us to achieve our goal. Please read each section carefully and provide your signature. If you have any questions, do not hesitate to ask a member of our staff.

APPOINTMENTS

1. We value the time we have set aside to examine and treat your child. Please help us service you better by keeping or rescheduling appointments at least 24 hours in advance.
2. If you are late for your appointment (> 15 minutes). We will do our best to accommodate you. However, it may be necessary on certain days to reschedule your appointment.
3. We strive to minimize any wait time. Emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well child) visit.

Initials: _____

INSURANCE

1. It is your responsibility to provide us with accurate and timely insurance information. If the insurance company you designate is incorrect, you may be financially responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
2. If we are your primary care physicians, make sure our name appears on your card. If your insurance company has not informed you 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 in regard to covered services, participating laboratories, center and physicians. For example: A. Not all plans cover annual healthy physicals, sports physicals, or hearing and vision screenings. If there are not covered, you will be responsible for payment. B. For children younger than 2 years of age, 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; therefore, you will be responsible for payment.

REFERRALS

1. 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.
2. Advance notice of 3 to 5 business days is required for all non-emergent referrals. Retroactive referrals cannot be written. It is important that as questions arise, you contact your insurance company directly for final guidance and clarifications.
3. It is your responsibility to know if a selected specialist participates in your plan.
4. Remember, we must approve referrals before they are issued.

Initials: _____

FIANANCIAL RESPONSIBILITY

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances.
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.
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. If previous arrangements have not been made with our medical billing company, please do so to avoid any extra fees.
7. For scheduled appointments, previous balances must be paid prior to the visit.
8. We accept cash, checks Visa and MasterCard credit and debit.
9. A \$25 fee will be charged for any checks returned for insufficient funds.

Initials: _____

FORMS

1. There is no charge for physical forms given to practitioner at the time of your child's visit. However, should you lose your forms or bring them to the office at a time other than a scheduled physical exam, there will be a \$2 charge (\$2 for one set of forms) to replace them. Please allow 2-3 days for form to be filled out.
2. Any additional school, camp, or sports forms are subject to a \$2 per form fee. Family and Medical Leave Act forms are \$5. Payment is due when the forms are dropped off. We require 2-3-day turnaround time.

Initials: _____

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 records is available to a \$0.73 per page fee.
3. We provide records of your child for visits rendered here at Peds In A Pod, LLC only. For copies of records from any other physician, you must request them directly from their office.

Initials: _____

PRESCRIPTION REFILLS

1. For monthly refills, we require 48 hours' notice, during regular business hours. Follow up appointment must be up to date in order to receive refills. Please plan accordingly.

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: _____

Parent/Legal Guardian Name: _____ Relationship: _____

Parent/Legal Guardian Signature: _____ Date: _____