Tots N Teens
Pediatric Clinic

OFFICE POLICIES

The purpose of this document is to establish and maintain a good physician-patient relationship. Keeping your patients informed of our office policies allows for the responsibilities to be clearly defined. It is our goal to provide clear communication so we can 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. You can call our office to request an appointment.
2. **You are responsible for paying your co-pay, meeting any outstanding deductible or coinsurance 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. If you are not able to keep an appointment, kindly give at least 24 hours' notice. **We will charge you $25 for a missed appointment, or for a cancellation made less than 24 hours prior to your scheduled appointment. If you have 3 no show, no call appointments you may be discharged from the practice.**
4. If you are late for your appointment (> 15 minutes), we will do our best to accommodate you. However, 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. Please make sure to bring your insurance card and driver's license to every visit.

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.**
2. If we are your primary care physician, make sure our name and/or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you will need to change it and provide us with a confirmation number before you are seen or you will be financially responsible for your visit.
3. It is your responsibility to understand your benefit plan coverage, for instance, covered services and participating laboratories. For example:
    a. **Not all plans cover sports physicals.**
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. Should you require a referral to a specialist, please allow 5 business days for all non-emergent referrals.
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: _____

FINANCIAL RESPONSIBILITY

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances, as well as for all non-covered items and services.
2. **Co-payments** are due at the time of service. A **$25 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. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **15** business days of your receipt of our bill.
5. If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a **$10 re-bill fee** for each 28 day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
6. For scheduled appointments, prior balances must be paid prior to the visit.
7. We accept cash, Visa, MasterCard, Discover credit and debit. We do not take checks.

Initial: _____

FORMS

1. There is a 3 business day turnaround time for any forms to be filled out.

Initial: _____

COPY OR TRANSFER OF RECORDS

1. If you want a copy of your child's records, or want us to send your child's records to someone else, please request and complete our Authorization to Release Medical Records. We will charge you a fee of $10 for copying.
2. If you transfer to another physician, as a courtesy to you, we will provide a copy of your child's records to one physician's office, free of charge. Turnaround time is 14 business days.
3. We provide records of your child for visits (including consultations from specialists) rendered here at Tots N Teens Clinics only. For any other records, you must request them directly from your previous doctor(s).

Initial: _____

I have read and understand these policies and agree to comply.

_____ _____

Patient Name **Date**

_____ _____

Signature of Parent or Responsible Party **Date**

_____ _____

Printed Name of Parent or Responsible Party **Relationship to Patient**