Acknowledgement of General Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for clearer communication lessening any future misunderstanding. ***Please read each section carefully and initial that you understand.*** 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 see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice. <u>There is a charge of $25 for missed appointments</u>.

2) If you are late for your appointment (greater than 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) 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. Also, after age 2 annual physicals must be scheduled 365 days from the last physical. There is one exception, BC HSA.

Initial: __________

Insurance Plans:

1) It is your responsibility to keep us updated with your correct insurance information. <u>If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.</u>

2) If you are enrolled in a "managed care" plan, (i.e. Carolina Access Medicaid, Tricare Prime, etc) we must be registered as your Primary Care Physician (PCP) in order to treat your child, unless you pay the out-of-pocket expense associated with the visit. That out-of-pocket will be collected at the time of service.

3) It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories.

- 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.
- 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: ___________

Financial Responsibility:

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

2) <u>*Co-payments*</u> 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) Any balance outstanding longer than 30 days will be forwarded to a collection agency.

7) For scheduled appointments, prior 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.

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.
4) Please be aware that some specialist require patient's date of birth & social security number before making appointment.

Initial: ___________

Forms:

1) There is no charge for a physical form when completed at the time of the visit. This is considered part of the visit. **However,** should you lose your form or need them completed after a visit; there will be a $10 charge per form.
2) Any additional school, camp, or sports forms are subject to a $10-per-form fee. Family and Medical Leave Act forms are $25. Payment is due when the forms are dropped off.

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 the medical record is available for $.50 per page; with a minimum of $10 should you wish to obtain a personal copy.
3) We provide records of your child for visits (including consultations from specialists) rendered here at Cross Creek 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 to complete the prescription for pickup/faxing/calling into the pharmacy. Please plan accordingly. ADHD medications must be picked up at the office and cannot be called / faxed to pharmacy.

Initial: ____________

Treatment of Minors:

The State of North Carolina mandates that we treat minors for certain issues WITHOUT the consent of their parent/guardian. Such items include sexually-related conditions (sexually transmitted diseases, certain vaccines, pregnancy, etc.). Due to the law, we cannot disclose any information concerning the visit without the consent of the minor. Under these circumstances, do you permit your child to use your insurance?

______ Yes ______ No

Initial: ____________

I have read and understand this office policy and agree to accept & comply with them.

______________________________	______________________________
Patient Name	*Date of Birth of Patient*
______________________________	______________________________
Responsible Party Name (Print)	*Relationship*
______________________________	______________________________
Responsible Party Signature Date	*Date*

On completion, please request a copy of this policy if you would like for your records.