# Alliance Pediatrics

## OFFICE POLICIES

The purpose of this document is to establish and maintain a good physician-patient relationship. Keeping our 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) In the interest of making ourselves available we have provided our patients with a Patient Portal which can be accessed from our website (www.Alliance-Peds.com) whereby you can request an appointment that meets your busy schedule. Our staff will contact you and confirm your request within 1 business day, or recommend other times based on the availability of your Physician. You may also call the office directly 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 $50 for a missed appointment, or for a cancellation made less than 24 hours prior to your scheduled appointment.**
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) Before making an annual physical appointment, or well check appointments, please check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
7) We schedule Well Child appointments according to American Academy of Pediatrics recommendations. With in 48 hours of hospital Discharge, 1 month, 2 month, 4 month, 6 month, 9 month, 12 month, 15 month, 18 month, 2 years and annually following.

**Initial: _____**

**Insurance Plans**

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, 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 usually a limit as to the number of allowable well visits per year. If the number of visits is exceeded and 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.
5) We **DO NOT** bill to secondary insurance.

**Initial: _____**

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**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. You must be up to date on Well Child checks and have been seen previously for any concerns that a referral is needed for.

**Initial: _____**

**Financial Responsibility**

1) According to your insurance plan, you are financially responsible for any and all co-payments, deductibles and coinsurances, as well as for all non-covered items and rendered services at the time of your visit.
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, or they won't receive cash pay discount.
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 **15** business days of your receipt of our bill.
6) 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. Should your account become delinquent, you shall pay the reasonable attorney fees or collections expenses of Alliance Pediatrics, if any.
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, MasterCard, Discover credit and debit.
10) A **$45 fee** will be charged for any checks returned for insufficient funds.
11) I authorize Alliance Pediatrics, its assignees, and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and any form of digital communications including, but not limited to, contact by manual calling methods, prerecorded or artificial voice messages, text messages, emails, and/or automatic telephone dialing systems. This consent includes any form of contact to a number for a cellular phone or other wireless device, regardless of whether I incur charges as a result. I hereby grant permission and consent to Alliance Pediatrics, its assignees, and third-party collection agents to contact me on the numbers I have provided for any purpose related to my account, including debt collection, by a live person or automated dialing device. **I understand that this consent may be revoked at any time, by informing Alliance Pediatrics, its assignees, and/or third-party collection agents that I no longer consent to contact at the phone numbers I have provided, or by these forms of communication.**

**Initial: _____**

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**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. Turnaround time is 3 business days.

**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 may charge you a fee for copying and shipping, as explained in the Authorization.
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 Alliance Pediatrics only. For any other records, you must request them directly from your previous doctor(s).
4) For your convenience, a full copy of your child's medical record is avaible for download on the patient portal.

**Initial: _____**

**Prescriptions**

**1)** For monthly medication refills you must be up to date on Well Child checks and Follow-ups, we require 3 business days notice, during regular business hours. Please plan accordingly.

**2)** By initialing below, I authorize Alliance Pediatrics to obtain my child's medication history electronically as part of an electronic health record.

**Initial: _____**

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

_____ _____

*Signature of Parent or Responsible Party* *Date*

_____ _____

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

***You may request a completed copy of this form for your records.***