Office Policies and Consent Forms

The Pediatric Center of Stone Mountain, LLC

General Pediatric, Adolescent Medicine & Behavioral Health Services

www.the-pediatric-center.com

Appointments

We value and respect the time we have set aside to see and treat your child. We do not double book appointments and we do not see "walk – in" patients. We see patients by appointment only.

If you arrive late for your child's appointment we must reschedule the appointment. There may be appointments available the same day or the next day, but there will be times that we are booked several days in advance. We will try to accommodate you the best we can, while making sure that other patients do not have to wait due to the late arrival of another.

If you are unable to keep an appointment, we require 24 hours notice to cancel medical appointments and 48 hours for counseling appointments.
There is a missed appointment fee of $50 for medical and $100 for counseling.

Our office uses an automated service to call and remind you of your appointments three days ahead of time, and the day before to make sure you can cancel or confirm. Please provide us with the best information to use.

My Child's Name Is: _____

My Phone Number Is: _____

My E-mail Address Is: _____
Please read and initial the following statement:

_____It is ok to leave an appointment reminder or practice notification on my voice mail, with an individual or on my answering machine

You may also receive reminders using one of the following methods. **Please circle the <u>one</u> you want**.

TEXT MESSAGE ---- My cell number is : _____
OR
E-MAIL ------ my e-mail address is: _____

Parent/ Guardian Signature: _____ Date: _____

Office Policies and Consent Forms

Healthcare Policy Information

Insurance Plans and Policies vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. We make every effort to verify participation and benefits prior to your visit, but you are responsible for know your benefits.

Identification cards have a member services phone number listed on the back of the card. We strongly suggest you call member services to confirm participation, eligibility and benefits before each visit to avoid any unexpected expenses.

Please understand, we are required to accurately report all services provided to the insurance company. It is possible your healthcare policy may apply co-insurance, deductible or a co-payment. If that happens, you will be notified by your healthcare plan on the Explanation of Benefits they send you as well as the statement we will send you. Prompt payment of your financial responsibility to the practice is appreciated.

If we are your primary care physician, make sure our name and/or phone number appear on your insurance 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.

Please **initial** beside each statement to acknowledge that you have read and agree to each statement of responsibility.

I agree to:

_____ provide complete, accurate and timely healthcare policy information for the patient.

_____ notify the practice if there is more than one healthcare policy; to include Medicaid, Peach Care for Kids, CMO and/or commercial insurance coverage.

_____notify the practice within three business days, in writing, to changes, terminations or additions to the patients' healthcare policy.

_____ respond within three business days to requests for additional information from the practice or billing company. Knowing that failure to respond could result in denial of the claim by the insurance company which would make me financially responsible for the unpaid charges.

Office Policies and Consent Forms

Financial Responsibility Information

Please **initial** at the end of each section to confirm you have read each policy

1. Co-payments are collected when that patient is being checked in for an appointment regardless of who is accompanying the patient.

2. Uninsured patients are required to pay a deposit at the time of check in and pay the balance at check out **before** leaving after the visit.

3. According to your healthcare policy, you are responsible for any amount that is not covered by your policy, applied to the deductible, co-insurance or co-pays.

4. The practice **will not** get involved in any domestic disputes. Legal documentation is required to change custodian or guarantor. It is your responsibility to provide legal documentation identifying who is financially responsible.

5. Your healthcare policy will send you, and the practice, an Explanation of Benefits after each claim is processed. This document identifies what your healthcare policy paid and, according to your individual policy, what your financial responsibility is.

6. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your payment for any personal financial responsibility is due within 10 business days of the date on the bill.

7. Unless previous arrangements have been made, any account balance outstanding longer than 28 days will be charged a **$15.00 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 60 days will be forwarded to a collection agency and be charged a **$25.00 collection agency fee**.

8. We accept cash, checks and all major credit cards. A $35.00 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms Information

Immunization forms (form 3231) and hearing and vision forms (form 3300) are provided during the well child checkup when they are performed. If replacement forms are needed, or forms such as camp forms, sport physical, pre-K and others, they must be requested 5-7 business days in advance. There is a small fee per form.

Initial: _____

Office Policies and Consent Forms

Referral Information

1. When possible, please provide advance notice for non-emergency referrals. These types of referrals usually take 3 to 5 business days to complete.

2. Please be sure to confirm the selected specialist participates in your health insurance plan and is on your policy. We make every effort to verify this information. However, it is not possible for the practice to remain current on all specialists and what plans he or she participates with.

3. Please notify the practice if you choose to see a specialist without a referral.

Transfer of Records

1. Any medical records you wish to be sent to us from another provider OR for us to send to another provider must be requested in writing and comply with all HIPPA requirements. We have medical records request forms available for both in-coming and out-going medical records requests.

2. Some requests may incur a nominal fee

3. Medical records requests may take up to 30 days. Initial: _____

Prescription Refills

1. Medications that need to be refilled on a regular basis require a 5-business day notice sent to us through the patient portal.

2. For ADHD medications, or other controlled substance medication refills, please allow 5 to 7 business days for processing your request. These refill request must also come through the patient portal. Please indicate if the Rx will be picked up, need to be mail (with address) or if electronic Rx is accepted by your pharmacy

3. For any medication request please indicate the name of the medication, the dosage of the medication, the name and location of the pharmacy you want it sent to and the best way for us to get back in touch in case there are questions.
   Initial: _____

I have read and understand the office policies and agree to comply and accept the responsibility for any payment that becomes due as previously outlines.

Parent/ Guardian Signature: _____ Date: _____