General Office/Financial Policies
PLEASE READ EACH ITEM AND INITIAL.

- ____All co-pays and deductible amounts must be paid at the time of service no matter what party accompanies your child to their visit. A $10.00 surcharge will be added for each unpaid copay.
- ____We accept cash/checks/debit cards/American Express/MasterCard/Visa and Discover.
- ____All returned checks are subject to a $30.00 service charge. If two returned checks are received on an account it will become a cash only account. We will accept payment by cash, money order or credit/debit card.
- ____Statements are processed monthly. All delinquent accounts are automatically turned over for collection after 90 days if no response or payment is received. If an account is turned over for collection a 30-day notice will be given and the patient is dismissed from the practice.
- ____We accept and file insurance as a courtesy. If we do not participate with your insurance, payment in full is expected at the time of service unless arrangements are made in advance with our billing department.
- ____It is your responsibility to understand your insurance policy and coverage limits. We strongly advise you to be familiar with your policy. It is your responsibility to notify us immediately of any change in your insurance.
- ____All insurance cards must be presented at each visit. You will be responsible for your visit expense at the time of service if current insurance information is not available for verification.
- ____At least a 48-hour notice is required for all prescription refills, referrals, shot records and other procedures/paperwork. Please give a 7 day notice for controlled substance refill requests.
- ____If you are more than 15 minutes late for your sick appointment you will have to wait and be worked back into the schedule for that day if possible.
- ____We ask that you arrive 10 minutes early for each well visit appointment. Due to paperwork and time requirements for well visits there is no grace period for arrival. If you are late for your well visit you will have to reschedule.
- ____If two well visits or a total of three appointments are missed without prior notification to our office patient is subject to a 30-day notice and dismissal from the practice. PLEASE NOTIFY US IN ADVANCE IF YOU CANNOT KEEP YOUR APPOINTMENT. A $25.00 "No Show" fee will apply for all missed appointments without prior notice.
- ____We provide one complimentary copy of medical records to the patient or to a third party with a signed medical records release form. All subsequent copies are $25.00.
- ____We see patients by appointments only. We cannot accommodate walk-ins.

CONSENT FOR TREATMENT

CONSENT: By signing below I authorize Pediatric Partners, LLC and such assistants as they may designate to carry out diagnostic procedures and tests to better diagnose my child's condition(s) and to administer such treatments and medications as indicated. Further, I understand that the above-mentioned policies are to provide efficient and equitable care to all patients. By signing below I agree to observe the office policies and understand that they may change from time to time without notice to allow for proper and expedient care to all patient and families.

_____DATE:_____
(Parent or Guardian if Minor)

PRIVACY NOTICE

PRIVACY INFORMATION: Pediatric Partners, LLC considers all protected health information (PHI) confidential and as such will disclose only the information that is necessary to carry out treatment, insure payment or health care operation. Please reference our NOTICE OF PRIVACY PRACTICES for more information on potential uses and disclosures of PHI. You may review our NOTICE OF PRIVACY PRACTICES that is posted in our waiting area. Terms of our privacy practices may change and a revised NOTICE OF PRIVACY PRACTICES will be posted for review. You have a right to restrict how your PHI is used. We are not required to agree to the requested restriction, however, should we agree to a restriction it is binding. You have the right to revoke consent in writing, except to the extent that we have taken action in reliance on it. By signing below I understand and accept the above listed polices, consents and notices:

_____DATE:_____
(Parent of Guardian if Minor)