

# New Patient Registration

## BRYN MAWR PEDIATRICS

### Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, please do not hesitate to ask a member of our staff.

#### Appointments

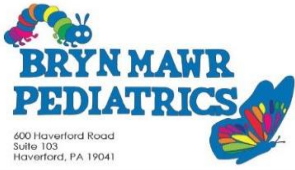
- We value the time we have set aside to see and treat your child. If you are unable to keep an appointment, we would appreciate 24 hours' notice. As of June 1, 2013, there is a charge of \$25.00 for missed appointments.
- If you are late for your appt ( $\geq 15$  minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- We strive to minimize any wait time. However, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
- Same day sick appointments are used on a first-available appointment basis.
- Appointments for additional children should be made by phone prior to coming to the office. We need to schedule enough time to see the additional children, and it is unfair to try to "squeeze in" a second child while there are other patients with appointments waiting to be seen.
- Before making an annual physical appointment, please check with your insurance company as to whether the visit will be covered as a well-child visit.
- Please schedule your next appointment when you leave.
- Please avoid use of cell phones in our office.

Initial: \_\_\_\_\_

#### Insurance Plans

- It is your responsibility to keep us updated with your correct insurance information.
- If we are your primary care physician (PCP), make sure our name appears on your card. If your insurance company has not yet been informed that we are your PCP, you may be financially responsible for your current visit.
- It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories.
- 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.
- For families who have high deductible plans, some office visits may require additional tests or labs that you may be responsible for. If you have any issues with this expense, please discuss this with the doctor prior to us performing the tests or labs.
- **All newborns MUST be added to your plan before the one month exam. You will be responsible for payment at the one month visit if your child is not added to the plan. Reimbursement will be made to you if insurance is backdated to that visit and is paid to us by your insurance company.**

Initial: \_\_\_\_\_



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## Referrals

- Advance notice is needed for all non-emergent referrals, typically a 48-hour notice.
- Please have the specialist name, provider number or NPI, and the location of the office when requesting a referral.
- It is your responsibility to know if the selected specialist participates in your plan.
- Remember we must approve referrals before they are issued.

**Initial:** \_\_\_\_\_

### Financial Responsibility

- According to your insurance policy, you are responsible for any and all co-payments, deductibles, and coinsurances.
- Co-payments are due at the time of service.
- Self-pay patients are expected to pay for services in full at the time of service.
- For scheduled well exams, all outstanding balances must be paid in full prior to that visit.
- We accept cash, check, and credit (Visa, Mastercard, and Discovery).
- A \$25.00 fee will be charged for any returned checks.

**Initial:** \_\_\_\_\_

### Forms and Transfer of Records

- As of January 15<sup>th</sup>, 2020, there is a \$15.00 form fee for all forms requiring a physician's signature.
- Transfer Record fee (prices vary due to size of chart)
- \$25.00 No-Show Fee
- \$25.00 Fee for Returned Checks

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due, as outlined previously.

Patient Name : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Responsible party name : \_\_\_\_\_ Relationship to patient : \_\_\_\_\_

Date : \_\_\_\_\_