Hartford Area Pediatrics, P.C.
21B Arts Center Court Avon, CT 06001
Phone 860-678-9400 – Fax 860-678-9480
info@hapediatrics.com

Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Please read each section carefully and initial. 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 have scheduled an annual physical appointment and you are not able to keep the appointment, we would appreciate 24-hour notice to offer that appointment to another patient. There is a charge of **$25 for appointments that are missed or cancelled less than 24 hours prior to the appointment.**
2. If you are more than 10 minutes late for your appointment we may need to reschedule.
3. We strive to minimize wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Initial: _________

Insurance Plans and Financial Responsibility

1. It is your responsibility to keep us updated with your correct insurance, personal address and contact information. Please make sure that you select us as your primary care physician if your policy requires one to be selected.
2. It is your responsibility to understand your benefit plan with regard to covered services.
   a. Not all plans cover annual well visits, vision, hearing, development/behavioral screenings. If these are not covered, you will be responsible for payment.
   b. Insurance plans will often apply laboratory testing done in our office to your deductible/coinsurance.
3. **Copayments are due at the time of service**.
4. Self-pay patients are expected to pay for services in FULL at the time of the visit. We do offer a self-pay discount.
5. If previous arrangements have not been made with our billing specialist, all prior balances must be paid at the next visit.
6. **The accompanying parent or adult is responsible for full payment at the time of services or at the child's next scheduled appointment**. It is your responsibility to work out payment of your child's medical care between the custodial and noncustodial parent. We will provide the accompanying parent with a receipt of payment if requested.
7. Would you like to **keep an HSA or credit card on file**? We will run the card when we receive the EOB from your insurance company. ***Yes / No***
8. Would you like to opt out of paper statements and pay through the electronic statement link via email/text? ***Yes / No***

Initial: _________

Prescription Refills

1. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.
2. Some medications may require your child to be monitored every 3-4 months. Please make sure to schedule your child's medication evaluation appointments prior to requesting a refill.

Initial: _________

Preferred Pharmacy Name ____ City ______________ State _________

Forms / Records / Letters

1. There is no charge for school forms given at the time of your child's visit. This is considered part of the visit. If you need additional forms or letters, there will be a $10 charge.
2. If you need to transfer to another physician, we will provide a copy of your immunization record and the child's last well visit free of charge, as a courtesy to you. We require 48 hours' notice.
3. If a copy of the complete medical record is needed, there is a fee of $25 that is due prior to releasing the record. Please allow our office 2 weeks to release the medical records to you or the new physician.

Initial: _________

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 (s) ____

Parent/Guardian Name ____Relationship ___________________

Parent/Guardian Signature ____Date _______________