Madison Irving Pediatrics, PC

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, 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. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. Patient may be at risk of discharge from the practice if three (3) appointments are missed.

2. If you are late for your appointment (greater than 15 minutes), we will do our best to accommodate you. However, if necessary and due to the schedule, it may be necessary to reschedule your appointment.

3. We strive to minimize any wait time; however, emergencies do occur and could expand your wait time if necessary. We appreciate your understanding.

Initial: _____

Insurance Plans

1. Insurance plans we contract with are: Excellus BC/BS- including Child Health Plus, Cigna, Aetna, Fidelis, Molina, United Healthcare (NOT Community Plan), Empire Plan, UMR, Martins Point, Tri-care Standard, MVP, GHI, and Medicaid.

2. It is your responsibility to keep us updated with your correct insurance information. If your insurance is not active at time of service, you will be responsible for payment of the visit or asked to reschedule (not a sick visit) when insurance is active.

3. Fidelis Care requires you to choose a PCP (Primary Care Physician), you must have one of our providers listed as the PCP. If PCP is not correct claims will not get paid by insurance and you may be responsible for the bill. We have forms in the office that can be signed, and our staff can send it to Fidelis to be updated or you can call Fidelis to change the PCP at 1-888-FIDELIS.

4. It is your responsibility to understand your benefit plan regarding, for instance, covered services and participating laboratories.

Initial: _____

Prescription Refills

1. For monthly medication refills we require 48-72 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

Financial Responsibility

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

2. **Co-payments** are due at the time of service. A $10 service fee will be charged to your copayment if the co-payment is not paid by the end of that business week.

3. Self-pay patients are expected to pay for services in FULL at time of the visit.

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4. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 days of your receipt of your bill.

5. If previous arrangements (payment plan) have not been made with our billing office, any account balance outstanding more than 90 days will be forwarded to a collection agency.

6. We accept cash, checks, all major credit cards and debit. If using a health savings card, please make sure you get a receipt to submit for your records.

7. A $35 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms

1. There is no charge for the Physical Authorization form given at the time of the Physical Exam. However, if a copy is needed after it was given there will be a $10 fee.

2. Any additional school, camp, FMLA or sports form will be subject to a $10 fee.

3. We require 3-day turnaround time for any requested forms.

Initial: _____

No Show Policy

1. As we understand that emergencies arise that may cause you to miss an appointment, if you cannot make an appointment please call our office.

2. 3 no-shows (appointments missed) in a year for a child may result in discharge from our practice. A family is allowed only 5 no show appointments in a year.

3. Additionally, if siblings miss a "double booked appointment", we will no longer book appointments back to back.

4. If we have to make the difficult decision to discharge one child, the entire family is dismissed.

Initial: _____

Notice of Privacy Practices

1. We at Madison Irving Pediatrics are required by law to maintain the privacy and confidentiality of patient information and provide individuals with the attached Notice of Privacy Practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer: Janessa Toole in person or by phone at our main number.

3. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document.

Initial: _____

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

Patient Name(s): _____

Responsible Party Member's Name: _____ Relationship: _____

Responsible Party Member's Signature: _____ Date: _____