PAL
Pediatric Associates of Lawrenceville, LLC

Office Policies and Procedures

Child's Name_____ DOB_____
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Please Initial

_____ **PHONE SYSTEM**: *When you call our office, the phone system will be answered by our automated telephone system. Please listen carefully to the menu so that your call is directed to the appropriate department with little or no waiting time.*

_____ **CELL PHONES**: *PLEASE TURN CELLULAR PHONES ON VIBRATE BEFORE ENTERING THE BUILDING*

_____ **WALK-INS**: *If you walk in without an appointment, you may be directed to the Urgent Care Facility or the Emergency Room.* **We work by appointment only. You may be subject to a $50 convenience fee for walk-ins in addition to your copay.**

_____ **SICK VISITS**: *If your child is sick, please make an appointment as early in the day as possible. We work by appointment only; no walk-ins.* **Patients arriving later than 15 minutes after the scheduled appointment time will have the option to reschedule or wait for the next available appointment that day.** *Please be courteous and notify us as soon as possible if you will not be keeping your appointment, so that we may offer the appointment time to another sick child.*

_____ **HEALTH CHECKS**: *Try to schedule the health check appointment for your child in advance. This will enable us to accommodate your schedule and allow your child's physician to spend ample time answering your questions and evaluating your child. We recommend frequent check-ups during infancy and yearly beginning at three years of age. We believe these visits are important to assess growth and development, as well as to offer advice regarding safety and emotional issues that are an integral part of a healthy childhood.* **Patients arriving later than 15 minutes after scheduled appointment time will need to reschedule.** *We understand that situations arise where you cannot keep an appointment. Kindly notify us 24 hours in advance if you are unable to keep an appointment.*

_____ **SAME DAY SICK and WELL Appointments**: *Most insurance policies cover Well Child Exam at 100% with no out of pocket expense to the family however, if your child is in the office for a well child exam and is actually sick or requires a prescription, our providers must document accurately which will result in* **your insurance company** *requiring your office co-pay for that visit.*

_____ **NO SHOW / MISSED APPOINTMENTS**: **Missed appointments will be charged a $100 "No Show Fee,"** *These fees are not covered by your insurance. To avoid such fees please attend all scheduled appointments or call our appointment line at least 24 hours in advance to cancel the appointment.* **Please note that 3 "No Shows" within a calendar year will result in dismissal from the practice.**

_____ **IMMUNIZATIONS**: *The Providers of this practice have made it a policy to immunize all patients of this practice.* **If it is your choice not to immunize your child(ren), you will be asked to find a new pediatrician.**

_____ **SATURDAY HOURS**: *We provide seasonal Saturday morning hours to see your child. Please call our office as early as possible to schedule an appointment. Phones are answered beginning at 9am.* **No walk-ins please**.

_____ **SIBLING POLICY**: *If you have another child with you today who is ill and is not originally scheduled to see the doctor, please immediately notify the front desk so that we may try to accommodate your child.* **DO NOT** *wait to inform us after you have entered the exam room.*

_____ **CONDUCT CODE:** *Our practice fosters the environment of mutual respect among our staff and the families we serve. The following conduct will* **NOT** *be tolerated at Pediatric Associates of Lawrenceville:*

- *Disruptive and/or rude behavior*
- *Use of inappropriate language*
- *Wearing apparel displaying divisive or obscene, language or imagery*
- *Apparent use of alcohol or illegal drugs (E.G., Blood-shot eyes, marijuana odor, etc.)*

If such conduct is observed by or reported to us: (I) You may be asked to leave, (II) We may contact law enforcement; and (III) we may terminate your child as a patient of our medical practice.

_____ **ADVICE PHONE CALLS**: *The triage line receives a high volume of calls. For your convenience, there is a voice mail system on this line. Please leave your name and phone number and spell your child's name and date of birth. One of our nurses will return your call as soon as possible. Morning calls are returned by 12:30pm, and afternoon calls by 5pm.*

_____ **PRESCRIPTION REFILLS**: *For medication that cannot be called in, please notify us* **72 hours in advance** *for routine prescription refills.*

_____ **RETURN TO SCHOOL/WORK NOTES**: *School/work notes will only be given for the day in which you were seen in the office. A parent note can be written for any additional days that the child has been out or will be out of school/work.*

_____ **MEDICAL/IMMUNIZATION RECORDS**: *Please give a minimum of* **72 hours** *notice for completion of school forms. This includes immunization records and physical forms. For a copy of the full chart, a medical record release form must be signed. Once we have the signed release form, there is a minimum of* **72 hours** *before these records become available. If a second release is requested a $25 charge will apply.*

If you are a new patient or have changed pediatricians or have received immunizations from the Health Department, please check with our staff to make sure we have your child's immunization records on file. In the instance your child's immunization records are not found or are not shown "up-to-date", it is your responsibility to obtain the missing records. We highly recommend that you keep a personal copy of your child's immunization records – we would be happy to make a copy for you!

_____ **INSURANCE**: *To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card* **each time you visit our office**. *This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further,* **if you provide us with incorrect insurance information, you will be responsible for the bill. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $25 re-filing fee.**

- *It is your responsibility to contact your insurance company and find out whether our providers are participating physicians within your insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our providers may participate in only one of these areas, not in all.*
- *It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy.*
  - *The following circumstances may result in you being billed directly:*
    - *~ we are not participating providers in your plan; insurance coverage is not in effect because of the date of visit*
    - *~ non-covered lab work is ordered/performed*
    - *~ or a non-covered service is performed or denied for the reason "not medically necessary"*
- *Co-payments are collected up front and are due at the time of service by the person bringing the patient for the visit.* **If you have a deductible plan, $80 of the visit is due at the time of service**

_____ **PERMISSION TO TREAT:** *If someone other than the parent or guardian is bringing the patient, a notice stating approval of the visit must be signed by the parent/guardian and presented at check-in. Also, please ensure that you send payment for the visit.*

_____ **REFERRALS**: *Referrals may be needed for specialists, emergency room visits, urgent care visits, etc. It is your responsibility to determine if your insurance requires a referral for health care visits outside of our office. If you do need a referral, please contact our office with an appointment date and time. We need* **72 hours** *to obtain a referral from your insurance.*

_____ **LABS X-RAYS, OR OTHER AMBULATORY CARE SERVICES**: *If labs, x-rays, or other ambulatory care services are required beyond your office visit,* **it is your responsibility to know where your insurance company covers you to go for these services**. *Each insurance company contracts with different companies.*

_____ **MEDICAL HOME**: *We work hard to provide comprehensive medical care and serve as your medical home. To that end, we expect that you contact our office FIRST before seeking specialty care or heading to Urgent Care.*

_____ **PATIENT PORTAL**: *We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, Office Practicum for the exclusive use of established patients. The Patient Portal is designed to enhance patient – physician communication. We strive to keep all information in your records correct and complete. If you identify any discrepancy in your records, please notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information. The Patient Portal provides access to the following services:*

• Request appointments • Request prescription refills • Fill out growth and developmental surveys • View your medical records • Receive educational material • View current and past statements • Pay bills online • Send messages to clinical staff • Receive health maintenance reminders

_____ **Credit Card on File/Deductible Plans:** *To expedite processing of payments, we require a credit card remain securely on file at all times. Depending on your plan's copayment or deductible policies, a minimum charge of $50 will apply at the time of service.*

_____ **Summary of fees for services that are not covered by insurance:**

No Show Fee per Child	**$100**
Walk-In Fee	**$50**
Complex forms to be completed ie. Katie Beckett, FMLA, DME forms	**$50/each**
Transfer Records Out (First time request free)	**$25 per patient** **$50 max per family**

I have read and understand the above-mentioned policies, procedures, and notices.

*Print Name*_____

*Relationship to Child*_____

Signature _____ *Date* _____