

ALL STAR PEDIATRICS, PC
OFFICE POLICY (updated 4/1/23)

Our goal is to provide and maintain a good physician-patient relationship. Informing you 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 each section. 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 do require a 2-hour notice to cancel.
2. If you are late for your appointment (over 15 minutes), this will result in a “no show” charge. We will do our best to fit you into the schedule the same day but depending on the schedule we may have to reschedule your child’s appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding,
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
5. Any portal or phone communication that requires medical decision making (photos to review, a change in medication, a new problem) will result in a telehealth or phone consult fee billed to your insurance.
6. We offer appointments on weeknights (after 5pm), weekends and holidays. Please note there will be a \$15.00 extra charge for these appointments.
7. No Show/Cancellation: Please give us the courtesy of 2 hours’ notice to cancel your appointment. If an appointment is cancelled with less than 2 hours’ notice or missed completely this will result in a \$100 charge per appointment missed. The second no show may result in dismissal from our practice.
8. The last well visit (physical) is the summer of high school graduation. We will see children for 1 year after this date for acute care visits and continue chronic medication. One year after graduating high school our patients will need to transition to an adult provider.

Initial: _____

Insurance Plans:

1. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designated is incorrect, you will be responsible for payment of the visits and to submit the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regards to covered services and participating laboratories. For example:
 1. Not all plans cover annual healthy (well) physical, sports physical or hearing and vision screenings and surveys, you will be responsible for payment.
 2. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
3. It is your responsibility to know if a written referral or authorization is required to see a specialist.

Initial: _____

Financial Responsibility

1. According to your insurance plan, you are responsible for all co-payments, deductibles and coinsurances.
2. Co-Payments are due at the time of service. A \$5.00 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of the business day.

- 3. Self-pay patients will be given a Good Faith Estimate prior to the visit if we are aware of your self pay status. Payment is expected in full at the time of the visit. A \$5.00 service fee will be charged if not paid on that day and no arrangements are made prior.
- 4. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- 5. Patient balances are billed on the 15th of the month. On that statement we will let you know what day of the month we will be charging your credit card on file. If you have a problem with the bill please contact our billing department before that date. If you do not use your credit card on file, remittance is due within 10 business days of your receipt of your bill.
- 6. If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a \$5.00 rebill fee for each 28 day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency and you will be dismissed from the practice.
- 7. For scheduled appointments, prior balances must be paid prior to the visit.
- 8. If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card or a copy of a personal credit card to remain on file.
- 9. We accept cash, checks, Visa, MasterCard and Discover.
- 10. A \$15.00 fee will be charged for any checks returned for insufficient funds.

Initial ____

Video or Audio Recording

We do not allow video recording or audio recording of our staff members without their permission.

Initial _____

Transfer of Records:

- 1. If you transfer to another physician, we will provide a copy of your immunization records and last visit to the physician free of charge as a courtesy to you.
- 2. A copy of your complete record is available for a \$20.00 fee and a Transfer of Medical Records form will need to be completed.

Initial _____

Prescription Refills:

- 1. For monthly medication refills, we require 48 hour notice during regular business hours and you must be up to date with office visits. You may submit that request through the patient portal.

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: _____

Responsible Party Name _____

Responsible Party Signature _____

Relationship _____

Date: _____