PREMIER PEDIATRICS COASTAL, PA
Office Policy

Patient name: _____DOB: _____

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.* If you have any questions, do not hesitate to ask a member of our team.

Appointments:

1) We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your 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) We will make every effort for you to see the provider of your choice but under certain circumstances it may not be possible. We strive to provide the quickest, quality service with minimal wait time.

Financial Responsibility:

Please note that we provide services to our patients, not to the insurance companies and our patients are responsible for the payments. If for whatever reasons your child's insurance company denies paying us, you will be required to pay.

Insurance Pay patients:

1) If your child is covered by a commercial insurance plan that we accept, we will file a claim to your carrier. You will be expected to pay any co-pay, co-insurance, non-covered services, and or any deductibles at the time of service.
2) It is your responsibility to keep us updated with your correct insurance information. If your child is covered under a HMO plan, please be aware that you have to choose one of our providers as the primary care physician, his can be done by informing your insurance company and provide them with the correct information. If your child has a secondary insurance that we were not informed of, or the insurance company you designate is incorrect, you will be responsible for payment of the visit.
3) Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment. It is your responsibility to understand your benefit plan with regard to, for instance, covered services including referrals and prior authorizations, and participating laboratories.
4) When your child comes for a well visit and found to have any sickness/ problems and our providers had to address the sick condition by providing counseling and/ or prescription and/or specialist referral, it will be considered a "Sick/Well" visit and billed accordingly. Opposite is also true. If your child came for a non-life-threatening sick visit and found to be due or overdue for well visit, it will be done also. You are required to pay applicable co-pay /deductibles, for the sick portion of the visit.

Self-pay patients:

1) Self-pay patients are expected to pay for services in FULL at the time of the visit. We offer a discounted sliding scale rates for patients without insurance.
2) 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.

Statements/Previous balance/payment info:

1) Except for rare exceptions generally we do not mail statements but send electronically. We expect you to pay within **10** business days. There is an 18% annual (1.5% monthly) interest charges for past due balances.
2) If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a **$5 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency and a fee will be charged.
3) 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.
4) A **$30** fee will be charged for any checks returned for insufficient funds and payment is expected within 7 days or it will be turned over to the District Attorney's office.

Well Visit / Immunization:

1) We follow AAP (and your insurance company) age specific well visits and immunizations guidelines. Well visits must be done irrespective of whether you want to immunize your child or not. ***Frequent missing of well visits may lead to discharge from our practice***.

2) We strongly recommend immunization of your children. If you choose not to immunize your child, you are required to sign vaccine refusal forms as requested by our staff and assume all risks associated with non-immunization.

Quality Measures (HEDIS):

1) As per insurance quality guidelines we cannot order a test or send to a specialist as per your request. It must be justified. Also, we are required to report timely well visits, immunizations, BMI and obesity counseling.

2) The Insurance requires that ER and specialist visits, expensive prescriptions and procedures are to be reduced also.

School Excuse:

Excuses are given for the days when patient is seen or if authorized by our providers to keep the child home for certain days. If we didn't see the child during an acute illness, we cannot give any excuse retroactively for extended period.

Forms:

1) Forms are completed for those whose accounts are in good standing. Delinquent accounts must be brought current before forms will be released. Forms must be paid for before they are released. Payment is due when the forms are dropped off.

2) Blank forms will not be accepted.

3) There is no charge for blue or yellow form given at the time of your child's visit. This is considered part of the visit. However, should you lose your form; there will be a **$1** charge per form to replace them.

4) Any additional school, camp, or sport forms are subject to a **$5** per form fee.

5) We require a **48-hour** turnaround time.

Transfer of Records:

1) If you transfer to another physician, we will provide a copy of your immunization record and your last physical to your physician, free of charge, as a courtesy to you. We need **48-hour** notice.

2) A copy of your complete record is available for a **$1** per-page fee for the first 25 pages and **0.25** cents per page thereafter once HIPPA form is signed.

3) We only provide copies of records (including consultations from specialists) rendered here. For any previous records, you must request them directly from your previous doctor(s).

Referrals:

1) Referrals are done only after patient has been seen in our office for the condition the referral is being sought.

2) If your child is being managed by a specialist and getting certain medications, formula or services, without any documents from the specialist we won't be able prescribe them.

Prescription Refills:

1) ADHD stimulant medication refills are done only during monthly office or telemedicine visits. They Lost prescriptions are not filled until due time.

2) If we suspect any medication diversion, we will not continue prescribing the same medications.

3) We generally do not prescribe narcotic pain medications or controlled anxiety medications.

4) All other maintenance medications (i.e., asthma, allergies, and bedwetting etc.) are refilled only if child has been seen within 3 months. If not, an appointment is needed before refills are done.

5) No antibiotics are prescribed or refilled without a patient evaluation in our office.

Prior authorizations:

We submit all prior authorization requests to the insurance companies on a timely manner. Approval or denial by the insurance companies solely depends on them and we are not able to give you any time how long it will take.

AUTHORIZATION TO LEAVE MESSAGE ON VOICE MAIL/MACHINE AND TO RECEIVE TEXT MESSAGES:

I acknowledge that it is my right to refuse to authorize reminder calls and other type of detailed messages be left on my voice mail and/or message, or received by text. This authorization can only be revoked in writing. _____ (initials).

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): _____ DOB: _____

Guarantor Name: _____ Relationship_____

Signature: _____Date_____

Revised: 01/01/2023