FINANCIAL AND OFFICE POLICIES

Patient Name_____. Date of Birth_____

Thank you for choosing Fifth Avenue Pediatrics for the care of your child. We welcome you to our practice! We are committed to providing exceptional and compassionate pediatric health care. You will be greeted with friendly faces, cared for by well qualified medical staff, examined and treated by only board-certified pediatricians.

BASIC POLICIES: Please initial each paragraph acknowledging you understand and agree to each policy

_____INSURANCE: **Please be prepared to provide a copy of your insurance card at EVERY visit.** Your insurance policy is a contract between YOU and the INSURANCE COMPANY. As a courtesy, we will bill your insurance carrier for services rendered if the proper paperwork is provided. The agreement between you and your insurance carrier is private, and we are not privy to the contract. If services are not covered, we will have to bill you directly. It is your responsibility to pay any deductible, co-insurance, or any other balance not paid for by your insurance company. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for the care provided. If you change insurance carriers, you MUST notify us immediately. If new insurance information is not provided **within 30 days of visit**, you will be financially responsible for the visit.

_____PRIMARY CARE PHYSICIAN: Many insurance companies require you to choose a primary care physician for your child. It is your responsibility to be sure one of our physicians is listed as the primary care physician with your insurance company. Otherwise, you must seek care from the primary care physician listed for your child in order for services to be covered.

_____NON-COVERED SERVICES: Please be aware that some services we provide may be non-covered services or are not considered necessary or reasonable under your policy but have been deemed medically in the best interest of your child by the physician. **Any care not paid for by your insurance will require full payment upon notice of claim denial.** Periodic preventative health services may or may not be covered under your health care policy or may have annual limits. Our office follows American Academy of Pediatrics well visit schedule and requires all patients follow that schedule. Any care not paid for by insurance carrier will be your responsibility and payable in full by you

_____CO-PAYS: All co-pays are **due in full on day of services**, regardless of who has brought child to appointment (parent, adolescent self, nanny, grandparent, etc.). In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. Your co-pay is your contractual responsibility agreed upon by you and your insurance company. Your insurance company requires you to pay that portion at **EVERY VISIT**.

_____PAYMENTS: If you have a balance due on your account, you will receive a statement from our office. If you encounter financial difficulty, payment plans are an option that may be considered on a case by case basis.

_____RETURNED CHECKS: You will be charged a $30.00 fee for returned checks due to insufficient funds or closed account

_____NO SHOWS/CANCELLATIONS: If you do not show up for your appointment or give us 24 HOUR NOTICE of cancellation of appointment, there will be a **$25.00 fee for sick visit and $50.00 fee for well visit/medication check.** We have provided you with an appointment slot that could have been given to someone else.[1] Emergencies will be considered on a case by case basis. Fifth Avenue Pediatrics will send appointment reminders via text or email as long as we have updated information on file, but please realize this service is a courtesy and it is your responsibility to keep your scheduled appointment.

[1] Revised 9/2019

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_____FORMS: There will be a **$20.00 charge** for paperwork such as homebound forms, camp forms, sports physical forms, etc. not completed at an office visit. Payment will be collected at the time paperwork is completed. FMLA forms require a patient visit for completion. Please allow at least 2 business days for completion. Physical and vaccine forms will be provided at well visits, but additional copies will be **$20.00 charge per form.**

_____MEDICATION and REFILLS: Medication refills for ongoing medications will be provided without charge if within 3 months of a visit. Certain medications, such as ADHD medications and other controlled substances, 1) CANNOT legally be refilled if the patient has not been seen **within 3 months**, and 2) Must be picked up in person during normal business hours. **No medication refills will be given after hours**. **Antibiotics will NOT be prescribed without a visit.** Please allow at least 2 business days to process refills.

_____AFTER HOURS: One of our doctors is on call every day. If you have an **URGENT** issue that cannot wait until the office reopens, please call our office and follow the prompts. Our answering service will connect you with a nurse from Johns Hopkins All Children's Triage center to assist you. If a doctor needs to be contacted, and you have not heard from the doctor within 30 minutes, please call again. **If you call after hours with an URGENT matter, you must be seen in our office within 24 hours for a proper exam and assessment**. If you would like to leave a NON-URGENT message for when the office reopens, please follow the prompts and a staff member will return your call.

_____VACCINES: Our office does require our patients to follow a vaccine schedule. We routinely adhere to the CDC schedule for routine immunizations. Deviations from this schedule must be discussed and a goal for completion of immunizations planned. You will be asked to sign a waiver for any deviation in the routine schedule. Please be aware that if you intend on not vaccinating or fail to follow the agreed upon schedule, we will ask you to seek a new pediatric office as we want to protect all of our patients from vaccine preventable diseases. **If your child receives a vaccine during his/her visit and we are later notified that no insurance was effective for that date of service, you will be responsible for the full cost of the vaccine.** The Vaccines for Children (VFC) program provides vaccines free of charge to uninsured patients, but we must be made aware that they are un-insured at the time of the vaccination in order to be eligible.

I fully understand and acknowledge this agreement as stated above and I agree to comply. My signature also authorizes payment of medical benefits to Fifth Avenue Pediatrics, P.A. for services rendered and authorizes this office to release medical information and records regarding my child/children to my insurance company.

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Signature Parent/Guardian

_____

Print Name Parent/Guardian

_____

Date