Pediatric & Adolescent Center of NW Houston, PA
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 review our policy carefully.

Appointments

1. We value the time we have set aside to spend with you. If you are unable to keep your appointment, please notify us 24 hours in advance so that we may give another patient the opportunity for that appointment. We do charge a $40 no show/late cancellation fee. The fee is charged to the patient, not the insurance company, and is due on or before the patient's next office visit. In order to avoid this fee, please call our office at least 24 hours in advance to cancel or reschedule your well child/med evaluation appointment and at least an hour before your sick visit appointment. Failure to comply with our cancellation policy may result in dismissal from our practice.
2. If you are more than 15 minutes late for your appointment, we will do our best to accommodate you. On certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and we appreciate your understanding in advance.
4. All patients must complete the patient information forms prior to seeing the doctor and present a current insurance card. To protect your child's record, you must provide a driver's license or photo ID.
5. Services performed on a Federal Holiday, after "normal business" hours or worked in to schedule may be billed an additional fee.
6. Our practice has a Certified Nurse Practitioner on staff. She is trained to provide preventative care and management of common acute and chronic pediatric problems under the supervision of a board-certified pediatrician. Patients consent to see a Nurse Practitioner when they schedule an appointment with her. Patients may refuse to see the Nurse Practitioner and request an appointment with the Pediatrician.

Financial Policy

1. Our office participates in a variety of insurance plans. If we do not participate with your insurance plan, or your child does not have insurance, payment in full is expected at the time of service. We do offer a discount to "Self-Pay" patients. Self-pay patients are expected to pay in *full* at the times services are rendered.
2. According to your insurance plan contract, you are responsible for any and all co-payments, deductibles, and co-insurances. Copayments and estimated deductibles / co-insurances are due at the time of service.
3. If our office is unable to verify your insurance coverage at the time of service, you will be financially responsible for the visit at the time services are rendered.
4. It is your responsibility to keep us updated with the correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and responsible to submit the charges to the correct plan for reimbursement.
5. If your insurance company is an HMO or POS policy it may require you to choose a primary care provider (PCP). You will need to choose a physician from our practice. If we are not the designated PCP, you will be considered self-pay and financially responsible for the visit in full.
6. If your insurance requires a referral or authorization to see a specialist please find one contracted with your insurance company that you would like to see then call our office back with the information for staff to proceed with referral. Referrals can take up to 5 business days so please call in advance. Our staff does not find specialists for patients due to the many variables involved. If we have to redo the referral (parent changes the specialist before referral is expired or lets the referral expire without seeing the specialist) or if we have to do an urgent referral within 48 hours there will be a $40 fee due to the amount of time it takes to complete this process. If a fee is charged this will be the patient's responsibility, not billed to the insurance company and due prior on or before the patient's next office visit.
7. Our office verifies your coverage as a courtesy but there is no guarantee until the claim is processed. It is your responsibility to understand your benefit plan with regards to, for instance, covered services and participating laboratories. For example:
    a. Not all plans cover annual physicals, sports physicals, or hearing screenings. If these are not covered, you will be responsible for payment.
    b. Some insurances limit the number of allowable well visits per year and/or have a dollar maximum of benefits payable for well child services. If this benefit is exceeded, your insurance company will not pay and you will be responsible for payment.

c. Some insurance companies consider visits for ADD or ADHD as mental health and will not cover the claim for services rendered by a medical physician. In this case, you will be responsible for payment.

8. Your insurance company may request that you supply information to them directly in order to process claims (i.e. coordination of benefits, pre-existing information). It is your responsibility to comply with these requests in a timely manner. Failure to do so may result in denial of claims which would then be the patients' responsibility.
8. In cases of divorce and /or separation, the person bringing the child in for treatment will be held responsible for the payment due at the time of service. For past due balances, the person requesting treatment is responsible for the balance on the account. We will be happy to provide a receipt if you need to seek reimbursement from another party.
9. All prior balances must be paid before your appointment.
10. We accept cash, check, Visa, and MasterCard. A $30 fee will be assessed for any checks returned for insufficient funds.
11. Statements are sent out monthly. Your remittance is due within 10 business days upon receipt of the bill. Any accounts with balances over 90 days with no activity can be turned over for collections and you and your immediate family members may also be discharged from the practice.
12. Overpayments will be refunded to the responsible party within 30 days of the request.
13. If you have any questions about your insurance or your bill, we are happy to help. However, specific coverage issues should be directed to your insurance company. You may contact the member services phone number on the insurance card.
14. If parent changes mind about an injection after it is ordered and drawn up the parent will be financially responsible for the cost. The insurance will not cover it.

Forms

1. We may charge for some forms including Family Medical Leave Act paperwork and any other forms to be completed by the physician. Payment is due when the forms are dropped off and we request a 5-day turnaround time.
2. Typically, a fee will be charged for medical letters requested to be written by the physician. This can vary depending on the nature of the letter.

Transfer of Records

We provide medical records for a fee. If you would like a printed copy the fee is $25.00 for the first 20 pages and $0.50 for each additional page. If you would like a copy of medical records on a CD, we charge a flat fee of $25.00. A release of information must be signed and please allow up to 15 business days for transfer of records.

Prescription Refills

For medication refills, we require 48 hours' notice. For controlled substance, we require 3-5 business days and appointment is required every 3 months.

Starting January 1, 2020, we will no longer see unvaccinated patients. We will continue to provide care for patients on alternate immunization schedule and unimmunized patients wanting to catch up on immunizations. We will continue to provide science backed information to help parents make an informed decision. Parents are encouraged to call their primary pediatrician and discuss their concerns on this matter. We care deeply for all our patients and wish to continue taking care of them to the best of our ability.

Signature of Understanding: I have read and understand the above stated office and financial policy.

Child(ren) Information:

_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Parent/Guardian Printed Name	Relationship to Patient
_____	_____
Parent/Guardian Signature	Date

Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Pediatric & Adolescent Center of NW Houston, PA, for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims benefits.

Parent / Guardian Signature/ Responsible Party _____ Date _____