



Dekalb Pediatric Associates Office Policy:

Please Initial:

Parent Name:

_____ **Phone System:** We strive to answer our calls, however, during times of heavy call volume, you may leave a message. Please listen carefully to the menu so that your call is directed to the appropriate department with little or no waiting time. Leaving multiple messages on multiple lines will delay your call back.

_____ **Cell Phones:** To set a good example for your children and to have a productive visit, please turn off your phone and electronic devices when any staff member is in the room.

_____ **Walk-Ins:** We do not accept Walk-Ins. We encourage parents to call us as soon as possible, we will try to accommodate as a same day appointment using a dedicated time slot.

_____ **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 10 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. **All sick children must go to the sick side waiting room.**

_____ **Health Checks:** Try to schedule the Well Child 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. **Patients arriving late (10 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.

_____ **Chadis:** Chadis questionnaires must be completed for **EVERY** well visit for children between the ages of 0-and 19 years and older. Your child will not be able to check in until Chadis is complete. We strongly encourage you to complete Chadis 3-5 days before your child's appointment.

_____ **NO SHOW / MISSED APPOINTMENTS:** will hereby be advised that after three "No Show" appointments, the child and siblings will automatically be discharged from the practice. Please attend all scheduled appointments or call our appointment line at least 24 hours in advance to cancel an appointment. Any calls with less than 24 hours will be considered a same day cancel. Same Day cancellations are considered a No Show and will count towards the "no more than 3 in a calendar year".

_____ **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 or children, you will be asked to find a new Pediatrician.**

_____ **SATURDAY HOURS:** If you No-Show or Same Day Cancel a Saturday appointment you will not be allowed to schedule any future Saturday appointments.

_____ **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



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room. If you are requesting an RX for another child leave a message at the front desk, do not disrupt the physicians flow.

_____ **Zero Tolerance:** We strive to create a relationship of mutual respect for each other and the families we serve. Verbal abuse will result in immediate dismissal from our practice.

_____ **SureScripts Prescription History:** I consent for my provider to access my child's prescription history via the electronic data base.

_____ **Nurse Phone Calls:** The nurse 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 medical assistant or nurses will return your call as soon as possible. Morning calls are returned by 1:30pm, and afternoon calls by 6pm.

_____ **After Hours Care:** A provider is always on-call and may be paged by our answering service upon request. Please save non-urgent concerns, refill requests and appointment scheduling for regular office hours. Excessive abuse of the answering service may result in discharge from the practice. Please disable any blocks from your phone, and keep your phone accessible to answer the call from the doctor. If you miss the call from the provider, listen to the message, as he or she will leave you instructions.

_____ **Prescription Refills:** Use our HEALOW application or Patient Portal to request refills. Please allow 48 to 72 hours for the request to be completed. Do not send multiple requests as this will cause a delay. A text message will be sent to you as soon as the prescription has been sent to the pharmacy.

_____ **Immunization or 3300 Records:** Please give a minimum of **72 hours'** notice for completion of forms. A \$15.00 will be charged for each duplicate 3300 or 3231 forms.

_____ **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 claim amount, if your claim needs to be re-filed, there will be a \$50.00 re-filing fee.**

- It is your responsibility to contact your insurance company and find out whether or not our Doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our doctors 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:

- ~ if we are not participating physicians in your plan; insurance coverage is not in effect on 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 are unable to pay your co-pay- Coinsurance or deductible the appointment will have to be rescheduled. If you have a deductible plan, 80% of the visit is due at



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the time of service. No charges can be made to a debit or credit card for under \$5 or a \$1 processing fee may be added to the charges incurred.

_____ **Collections:** If your account is sent to our collections agency a \$50.00 fee will automatically be added to the bill.

_____ **Statements:** All statements are Published to the Patient Portal. If you have an issue, see the office Administrator.

_____ **Self-Pay:** If you lose your insurance and decide to keep the appointment, you will be a self-Pay at the time of the visit. Dekalb Pediatric Associates does not reimburse, an itemized bill will be provided in case you need to submit the information to your insurance company. If you wish you could also re-schedule the appointment to a different day when your health insurance becomes active.

_____ **Permission to Treat:** If someone other than the parent or designated 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 or pay on line. They must also bring the health insurance and a valid government ID.**

_____ **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 need a referral, please contact our office at least **3 working days** in advance 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.

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

Child's Name _____ DOB: _____

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Child's Name _____ DOB: _____

Parent / Guardian Name _____

Relationship to Child _____

Signature _____ Date _____