Sunflower Pediatric Clinic

Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial where appropriate. 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. Well-child exams, scheduled follow up visits, ADHD appointments or scheduled consultation would require a **24-hour notice** cancellation or a $25 cancellation fee will be charged. “Same Day” visits require at least **2 hours** notice or a $25 expedite fee will be charged.

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) Any **new patient** who **fails to show** for their **initial visit** will unfortunately **NOT be able to reschedule**.

4) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Initial: _____

Insurance Plans

Please understand:

1) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

2) If we are your primary care physician, please make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

3) Preventative care is the primary focus of your child’s well-check exam. Discussing additional acute or chronic conditions or significant medical conditions during a preventative well-check can create another office visit fee and would result in additional charges and a co-pay or deductible/coinsurance amount depending on your health insurance plan. Any charges that are not part of the preventative care must be billed out as a separate code and you may be billed for those additional services.

4) 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 health (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.

b. 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.

5) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Cash Account

If you'd like to self-pay or have HSA and you are paying cash for services, you will receive a cash payment discount if the balance is paid in-full at the time of the service.

If the balance cannot be paid in-full at time of service, a payment plan will be established and you will be assessed the full amount due without any discounts.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.

2) It is your responsibility to know if a selected specialist participates in your plan.

3) Remember, we must approve referrals before they are issued.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co-payments are due at the time of service.

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.

3) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.

4) If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a $15 re-bill fee for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

5) For scheduled appointments, prior balances must be paid prior to the visit.

6) 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.

7) We accept cash, checks, Visa, and MasterCard credit and debit.

8) A $35 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Termination for our Practice

Our office values the physician-patient relationship. In certain circumstances if the relationship has been affected negatively or is no longer therapeutic, it can result in termination from our practice. The reason for termination could be but not limited to:

- Repeated noncompliance with therapies or treatments essential to the patient's safety as deemed medically necessary by the physician
- Failure to meet financial obligations
- Consistent or repeated failure to keep appointments without good cause and/or without notice of intent to cancel appointments
- Threatening, violent, abusive or patterns or repetitive rude or offensive behavior directed at a Provider, office staff, or other patients or visitors
- Attempts by the patient to use the relationship to illegally or improperly obtain controlled substances for non-therapeutic purposes, abuse of controlled substances
- The elects to terminate or expresses a desire to terminate the relationship

Divorce, Separation, & Custody Agreements

We believe that such matters should not enter into a child's medical treatment.

The individual who is requesting the medical treatment is responsible for the payment of the medical bills. We are not a party to your divorce agreement, you are. We will collect co-pays and deductibles from the attending parent.

"Joint Custody" means that each parent has equal access to the child's medical record. Without a court order, we will not stop either parent from looking at their child's chart or obtaining their child's test results.

We will not call the other parent for consent prior to treatment.

Unless stated in the court order both parents have equal rights and we can't get involved.

We will discuss with the accompanying parent information pertinent to the child's history and/or present exam.

Should the issues that come between parents become disruptive to our organization, we will discharge the patient from further treatment.

Initial: _____

Vaccine Policy

Our practice follows CDC vaccine recommendations. Our physicians do not accept patients who do not vaccinate their children. We also do not accept alternate vaccine schedules.

Initial _____

Medical Records & Form

We will provide copies of your medical records within 15 business days of receipt of signed records release and the nominal charge for your records. There are also nominal fees for forms such as insurance forms, school forms, FMLA, disability forms, etc. Please allow 5-7 business days to complete the forms. If Fees must be paid prior to completion of any form. Fees are set forth by the State of Texas and the Texas Medical Board. There is a charge of $20 for each expedited form. Expedited forms will be completed in 24-48hrs.

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

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.

PatientName(s)_____

Responsible Party Member's Name _____

Relationship_____

Responsible Party Member's Signature _____

Date _____