

THE CENTER FOR ADVANCED PEDIATRICS, PEDIATRIC ENDOCRINE AND DIABETES SPECIALISTS and URGI-KIDS OFFICE POLICIES (JANUARY 1, 2011)

Our goal is to provide and maintain good physician-patient relationships. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goals to provide the most comprehensive healthcare for your children. Please read each section carefully and sign at the bottom. On completion, return the signed acknowledgement page to the receptionist. The copy of the policy is yours to keep. If you have any questions, please do not hesitate to ask a member of our staff.

Appointments

- We value the time we have set aside to see and treat your child. We do not intentionally double book appointments so if you cannot keep that appointment, with ample notice we can give that time to someone else. If you are not able to keep an appointment, we require 24 hours notice for physicals and 48 hours notice for specialty appointments. If you make an appointment for a sick visit, and your child feels better prior to the appointment, please call and let us know you will not be coming in so that time can be given to other sick children. If you fail to let us know, a \$100 fee will be added to your account. We do make appointment confirmation calls for physicals and specialty appointments which gives you an opportunity to reschedule your appointments if you need to make a change, Therefore a \$200 fee will be added to your account for missed physicals or specialty appointments.
- If you are late for your appointment (10 minutes or more), we will do our best to accommodate you however, on certain days it may be necessary to reschedule your appointment.
- We strive to minimize any wait time however emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
- We require that all of our patients have yearly well child check ups. It is wise to schedule them a year in advance (at the current check-up) so that you will be sure to get the date and times that work best for you.
- Medical offices are required to comply with "Red Flag Rules" which were put in place to protect you from identity theft. At all visits we will be asking you (or the person accompanying the patient) to present the insurance card as well as a photo id. Please let us know the names and relationship of any other adult who might be bringing your child for their visits.

Insurance Plans

- We participate in most insurance plans however each plan varies as to the benefits that are covered. It is your responsibility to understand your benefit plan with regard to covered services. For example some plans do not cover hearing and vision; some do not cover well child visits, etc. If any service we provide is not covered under your plan, you will be responsible for payment.
- Physicians are only allowed a short window of time to submit claims for your visits. 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. We would be happy to resubmit the charges to the correct insurance company and would then reimburse you once they have paid us.
- If you have selected us as your primary care physicians, please make sure that you have notified your insurance carrier and that our name is listed on your insurance cards. If claims are denied because we are not listed as your PCP, you may be responsible for the cost of the visit.

Referrals

Some insurance companies require a referral before you can see a specialist. In most cases we cannot provide a referral without seeing the patient. If you require a referral for an existing condition that we are aware of, we do require at least 72 business hours notice to process the referral.

Prescription Refills

For medication refills we require 48 hours notice during regular business hours (Monday through Friday 9am to 5pm). Please plan accordingly. We do not process refills during nights and weekends.

Medical Records

- We adhere to the rules and regulations of HIPAA and enforce them to protect the privacy of your child. If your child is 13 years of age or older, we will require their permission to share our medical records with you.
- If you are transferring to another physician, we require 2 weeks notice to process your request and copy your records. There is a charge of \$0.65 per page as allowed by Connecticut State law which is payable in advance of processing your request. We do require written request and have a specific form for this purpose. If your child is older than 13 years, we will send directly to another physician. We have a form for this purpose.
- If you are registering as a new patient with us, we require your child's previous medical records prior to being able to be seen as a patient at our office. Once we have received and reviewed your records, an appointment will be made so that we can medically get to know your child.

Forms

Effective January 1, 2010 - The Center for Advanced Pediatrics will charge for ALL forms that parents/patients request to be filled out by a physician or nurse. Payment for the forms must be made before the forms are processed by the office. Blank forms cannot be accepted. Forms will only be accepted for completion if the sections that need to be filled out by the patient or parent are completed. We cannot accept forms that are faxed to our office, but will accept forms that are mailed. Please be sure to include the payment when you mail the form – checks are preferred – do not send cash in the mail. Fees for process forms are as follows;

1-2 pages --\$5.00 (1 double sided page); 3-4 pages -- \$10.00 (2 double sided pages)

5-6 pages --\$15.00 (3 double sided pages) 7-8 pages --\$20.00 (4 double sided pages) over 8 pages -- \$25.00

Forms can take as long as 2 weeks to complete particularly in the spring and summer. You will be called when the forms are completed and the forms will be waiting at the front desk. "Rush" jobs will be completed within 48 hours for an additional \$25.00. Due to the increased volume of form requests this service will not be available from the beginning of May to the end of September. If you would like your forms mailed to your home or another address, you must include a self addressed stamped envelope (SASE). Only accounts that are in good standing and patients with current physicals (within 12 months of the time the form is being completed) will be processed. We cannot fill out forms if your screening (eyes/ears) were done at school or by another physician without a note from the school or physician.

Financial Responsibility: Please be aware that before we can offer you an appointment time for any visit, prior balances must be paid prior to the visit .

- According to the contract you entered into with your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances at the time of your visit. Self pay patients are expected to pay for services in full at the time of the visit. If we do not participate in your insurance plan, payment in full is expected at the time of your visit. We will supply you with an invoice that you can submit to your insurance company for reimbursement.
- Copayments are always due at the time of service as per your policies requirement. We are not allow to see your child if you do not pay your co-pay. A \$25.00 service fee will be charged in addition to your copayment if the copayment is not paid by the end of that business day.
- The adult accompanying the patient to our office is responsible for payment of the applicable co-pay, deductible or coinsurance regardless of whether it is the parent or guardian. For instance if another family member brings your child to the office, they should have with them a copy of your insurance card and applicable payment. In divorce or separation situations, we do not split the financial responsibility nor do we bill 2 separate individuals. The adult accompanying the patient to our office is responsible for payment of the service.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB). Your remittance is then due within 10 business days of your receipt of your bill. We will charge interest as allowed by law and after 90 days if you have not satisfied payment, or made other arrangements, your account will be sent to collection and you will be responsible for any legal costs involved in collecting your past due account.
- We require you to keep a credit card on file with us. This will be kept securely and allow co-payment and balance payments to be paid when due. If you do not have a credit card, you will need to keep a minimum credit balance on your account of \$200.00. If you do not have a credit card on file or a credit balance with us, then a monthly billing fee of \$25.00 will apply for each month the balance is unpaid.
- ***For your convenience we accept cash, checks, debit cards and credit cards (Visa, Mastercard , Discover.) . A \$35.00 fee will be charged for any checks returned for insufficient funds and from that point forward we will accept only cash transactions.***

**Authorization of Treatment and Assignment of Benefits to The Center for Advanced Pediatrics,
Pediatric Endocrine and Diabetes Specialists and Urgi-Kids**

I _____ authorize The Center for Advanced Pediatrics to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school and camp forms. Etc.

I authorize payment directly to The Center for Advanced Pediatrics for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance.

I also affirm that I will reimburse The Center for Advanced Pediatrics for any payments my insurance company may have sent to me directly.

I understand that I am financially responsible for all co-payments, deductibles, co-insurance and any charges not covered under my insurance benefits.

I also understand that I am responsible for advising The Center for Advanced Pediatrics of any and all changes to my insurance coverage and will present The Center for Advanced Pediatrics with proper member identification and photo identification at the time of each visit.

I have read and understand the office policies presented to me on the accompanying pages and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Names: _____

Responsible Party: _____

Relationship to patient _____

Please print

Signature

Date _____

EASY PAY CONSENT FORM

I authorize The Center for Advanced Pediatrics to charge my credit or debit card listed below for the following:

- the balance of charges unpaid
- Copays and/or co-insurance
- Deductibles
- Services not covered under my insurance plan

I understand this form is valid until the expiration date of the listed card unless I cancel the authorization by written request

Cardholder's Signature

Date

Patient Name(s)		
Cardholder Name		
Cardholder Address		
City	State	Zip Code
<input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> Discover <input type="checkbox"/> Debit Card		
Credit / Debit Card Number _____ verification # _____ Expiration Date: _____		