Brighton Hill Pediatrics, RLLP
Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully.* 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. If you are unable to keep your appointment, we would appreciate 24-hour notice. You will be charged a $25.00 fee per no-show and may result in dismissal from the practice.
2. If you are late for an appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
5. We require a parent and/or guardian to be present at any well child check/physical and vaccine appointments.
6. We will charge a fee for any appointment on weekends and holidays. This additional fee will be billed to your insurance company and may or may not be covered.
7. Videotaping and photography in the exam rooms and hallways are prohibited due to privacy issues.
8. As your child's primary care medical office, we request that all well child/physical examinations are done here in our office.

Insurance Plans

Please understand

1. It is your responsibility to keep us updated with your correct insurance information. We require that you present your insurance card at each visit. **If the insurance company you designate is incorrect, you may be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2. Fidelis Care requires you to choose a PCP (Primary Care Physician), you must have one of our providers listed as the PCP. If the PCP is not correct claims will not get paid by insurance and you may be responsible for the bill. We have forms in the office that can be signed, and our staff can send it to Fidelis to be updated or you can call Fidelis to change the PCP at 1-888-FIDELIS.
3. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you may be responsible for payment.
    b. At your annual physical if the physician addresses any other issues that are not routine there may be an additional fee billed to your insurance company. <u>This fee may be subject to your deductible or co-pay.</u>
4. 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.

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. All referrals need to be set-up through our office.
4. If you cannot make the appointment we set up for you, it is your responsibility to reschedule it with the specialist.

Financial Responsibility

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2. **Co-payments** are due at the time of service.
3. Self-pay patients are expected to pay for services in FULL at the time of the visit.
4. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due in FULL within 30 days of your receipt of your bill.
5. If previous arrangements have not been made with our billing office, any account balance outstanding longer than 90 days may be forwarded to a collection agency. If this occurs you will be asked to find another health care provider.
6. For scheduled appointments, we would appreciate any prior balances be paid prior to the visit.
7. We accept cash, checks, Visa, MasterCard, and Discover.
8. A $20.00 fee will be charged for any checks returned for insufficient funds.

Forms

1. A Health Appraisal form along with a copy of your child's immunization will be given free of charge at the time of your child's well visit. However if a copy is needed after it was given there will be a $5.00 fee.
2. Any additional school, camp, FMLA or sports forms will be subject to a $5.00 fee.
3. We require 7-day turnaround time for any requested forms.

No Show Policy

1. As we understand emergencies arise that may cause you to miss an appointment, if you cannot make an appointment please call our office.
2. You will be responsible for a $25.00 fee for any missed appointments.
3. 3 No-Shows (appointments missed) within a family may result in discharge from our practice.
4. Additionally, if siblings miss a "double booked appointment", we will no longer book appointments back to back.
5. If we have to make the difficult decision to discharge one child, the entire family is dismissed.

Prescription Refills

1. For monthly controlled substance and antidepressant medication refills, we require a 7 day notice, during regular business hours. Please plan accordingly.

Transfer of Records

1. If you transfer to another physician, we will provide a copy of your immunization record and the last two years of your child's history to your physician, free of charge. This may take up to 4 weeks to process.
2. Any additional copies of your complete medical record are available for a $.75-per-page fee.
3. We provide records of your child for visits (including consultations from specialists) rendered here at Brighton Hill Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outline previously.

Patient Name(s):_____

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____