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 reserve the right to charge for missed or late cancelled appointments. This fee will not be covered by your insurance. 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.

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. 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.
7. 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.
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.

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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.
15. We do not file claims to automobile insurance. If your visit is a result of an automobile accident, you will be required to pay self pay. We will provide a receipt so that you may seek reimbursement.

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 or provider participates in your plan.

Forms

1. We may charge for shot records, school forms, camp forms, Family and Medical Leave Act forms, 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.
   (*Please ask the nurse to update your personal shot record at each well child visit)*
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 records for visits rendered by our physicians only. For any previous records, you must request from previous providers. A $25 fee will be assessed for a complete copy of your medical records. A release of information must be signed. If you transfer to another physician or we refer you to another physician, we will send that physician a copy of your last visit and pertinent records free of charge. Please allow 10 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.

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

Patient Name _____ Patient Date of Birth _____

Name of Parent / Guardian _____ Relationship _____

Parent / Guardian Signature/ Responsible Party _____ 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 _____