Pediatric and Adolescent Medicine
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OFFICE and FINANCIAL POLICIES
(Effective 11/7/2012)

Welcome to our pediatric and adolescent medicine practice. We look forward to caring for your family and being the best advocates we can be for your medical needs. Please take a moment to review our office policies and "sign off" per your agreement.

INSURANCE: We participate with a variety of insurance carriers. It is your responsibility to understand what your policy does and does not cover, including deductibles. You are asked to pay your co-pay (if any) at the time of service. Please be certain we have all of your current and pertinent insurance information and/or copies of your "active" insurance cards. You will be asked for this information prior to each visit. After we have received an explanation of benefits (EOB) from your insurance company, we may bill you for any additional charges that you are liable for under your contract, and as delineated in the EOB.

If we do not participate with your insurance carrier, payment is requested at the time of service. For your convenience, payment will be accepted in the form of cash, personal check, or MasterCard/Visa/Discover. Please be aware that YOU are responsible for submitting any invoices to your insurance company with which we do not participate.

Please note that there will be a $25 returned check fee and assessed late fees for late payments.

In the past it has been our practice to extend professional courtesy and waive co-payments. Waiving co-payments is a violation of the contracts we have with insurance companies and is now specifically prohibited.

ADDITIONAL CHARGES: As of January 1, 2004, our practice initiated an administration fee to cover the costs of the increased amount of time and paperwork required to practice effectively and serve your needs. This charge is $75 per family per year. The intent is an attempt to address the costs of these services (routine referrals, school and camp forms, brief telephone calls, etc.) without "nickel and diming" our families.

There will be additional charges for a complete copy of your children's medical records. Please provide us with a written request and expect a minimum of 5 business days for processing. Expect a charge of $25 per child's records.

Please give our office staff "due" notice of up to 7 days for needed referrals and school forms, and please provide self-addressed and stamped envelopes unless you intend to pick up the completed forms. Faxes will not be accepted for school and camp forms. Your child MUST have had a physical exam within 12 months prior to the forms being completed.

Many insurance plans require blood tests to be sent to designated laboratories they have contracted with. We will order and authorize blood tests as required and refer you to the free standing laboratory facility for blood drawing.

We are available to you by telephone "24/7" any time you have an urgent medical need. Please do not hesitate to call us after office hours for these urgent needs. Because many insurance companies reimburse telephone consultations, our office may submit claims to your carrier for the service provided. **We will not bill you for these services at this time.**

As stated, we are very accessible and want to be there when you need us. Please be courteous to us and other patients by letting us know 24 hours in advance if you need to cancel an appointment. We understand that "things" come up, but we reserve the right to charge a cancellation fee of $50.

If your child is on a medication that requires a monthly prescription (stimulant medication or controlled substance), he/she MUST have vital signs documented in the chart every 3-4 months along with an in-office review or the prescription will not be filled. Any chronically used medication must be re-evaluated in-office every 6 months. This is very important to the health of the child.

I authorize Drs. Coleman, Thillairajah and Greenberg to furnish all medical information necessary to process medical claims and request payment of government /Insurance benefits to either me or the physician accepting assignment. I hereby assign to the physician all payments for medical services rendered to me or my dependents, I understand that I am responsible for any amount not covered by insurance and that I will be charged a late fee, according to the schedule below, for any account 60 days past due.

$0-99	$10
$100 – 250	$25
$251—500	$50
>$500	$100

We would like to keep you as patients and prefer not to submit these delinquent claims to a collection agency. We encourage you to establish a payment plan if needed. If you make a good faith effort to pay amount owed we will be happy to continue to provide service. However, you will be responsible for the outstanding balance in total and any additional fees for recovery assessed by the collection agency.

PLEASE always keep an updated copy of your child's immunization records. If your child is adult age, give them a copy as well.

We see patients with appointments only. Even if it is urgent, please call before coming to the office.

I (We) have read the above policies and agree to their terms:

Name of Patient(s): ______________________________

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Parent/Guardian

Signature: ______________________________

Date: