Plant City Pediatrics Practice Guidelines and Policies

Patient Name: _____ DOB: _____

Please read and initial each line:

_____**No-Shows**: We require 24 hour notice of cancellation as a courtesy to other patients seeking services. Continued NO-SHOW APPOINTMENTS WILL RESULT IN DISCHARGE FROM THE PRACTICE.

_____**Appointments**: Our office will schedule appointments as a courtesy for patients and in consideration of your time. We do not accept walk-in's. Minors must be accompanied by a parent or guardian. ***Only 2 adults may accompany the child during the exam.**

_____**Emergencies:** Our providers will make every effort to receive your calls and respond promptly to urgent issues. If you do not receive an immediate response, you will call 911, receive paramedic intervention, or seek the nearest emergency room. **The answering service will not** schedule or cancel appointments or refill medications. Please be available to answer your phone after paging a provider if you have an urgent need.

_____**Prescription Refills:** It is our office policy that you should be responsible to know when your medications must be refilled, at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy or by notifying our office 5 days in advance. We can not take weekend, walk-in or after hours refill request.

_____**E-Prescribing:** E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. By initialing, you are agreeing that Plant City Pediatrics can request, and use, your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment.

_____**Antibiotics and Phone Encounters:** Our providers do not treat new patients or illnesses over the telephone. Prescriptions are not called in after office hours. Antibiotics are not called in without an office visit to support the necessity.

_____**Vaccine Policy:** We require that all new patients follow the Advisory Committee on Immunization Practice (ACIP) Vaccine Schedule. This schedule will not be altered in any way.

_____**Information:** You agree to provide the correct name, correct address, cell or other phone number, email address, insurance information, Social Security number, driver's license or picture identification at the time of registration or as requested by the practice.

_____**Financial Responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered. If a minor, or under guardianship, the parent or guardian accompanying the patient assumes this responsibility.

_____**Payment Methods:** We accept cash, check, and major credit cards.

_____**Well-Visits:** Are required at 1 week of age, 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and annually after 3 years of age. Non-compliance with well visits will result in discharge from the practice.

_____**Form Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: $25 fee for forms and letters (FMLA, letters, disability forms, etc.).

_____**Physical and Vaccine Forms:** Our office will provide physical and vaccine forms, as requested at well visits, free of charge. If forms are requested at another time, there is a $5.00 fee.

_____**Medical Records:** The medical chart is **the property of the practice.** However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to those published annually by the State of Florida Comptroller's Office. This fee is available upon request. Records to other providers are provided free of charge.

_____**Insurance Copayments, Deductibles and Coinsurance:** Payment is expected at time of service. Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles and coinsurance are to be paid at the time of service.

_____**Statement Policy:** Patient statements are sent each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company we are required to bill them for services rendered. The sending of a statement may be delayed until your insurance responds to a claim. You understand that such a delay does not alter our policy or patient financial responsibility and you will be liable for all service fees.

_____**Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense. The banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees.

_____**Notice of "Non-Covered Servies"** I am aware that some services performed by Plant City Pediatrics may be 'non-covered' by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

_____**Cell Phones: We require that cell phones be silenced when you enter the office area** and when your child is being examined. If the parent/guardian is on the phone, the provider will return when you are able to give them your attention during your child's visit.

_____**ADHD Patients:** We will refill ADHD medications after an initial visit by Neurology. Patients must be rechecked 1 month after a medication change and every 3 months to continue receiving refills. **We do not write prescriptions for psychiatric medications/antidepressants.**

_____**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Because of quality care considerations, the practice may discharge you for failure to comply with treatment plans. In addition, **we will discharge patients due to continued no-show appointments, disorderly conduct in the office, on the phone and with our staff.**

_____**Visit Charges: You may be seen for both a well visit and a problem/sick visit on the same day because you satisfy the requirements for both types of visits during one appointment. PLEASE BE ADVISED that your insurance company may apply some charges to patient responsibility. If you prefer to return for the problem visit on another day please advise the provider.**

____**Permission for Treatment:** Permission is hereby granted for physicians, employees, or agents of Plant City pediatrics to render such medical and surgical treatment as deemed necessary.

_____**Telemedicine**: We have decided, as a group, not to participate in this type of patient healthcare. As a Primary Care Physician we are responsible for the management of our patient's healthcare. We understand that telemedicine may provide immediate service, but we question the accuracy of the diagnosis and treatment provided without examination. As the parent, you have the right to utilize telemedicine if your insurance company provides this service. However, we strongly encourage you to follow-up in our office within 1-2 days.

Parent/Guardian Name/Printed:_____

Parent/Guardian Signature:_____**Date:**_____