OneFamilyPediatrics

Office Policy

Please initial on each line

_____*(initial)* Well Check-ups are Required

At One Family Pediatrics, we feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative health care at the following ages:

- Newborn period
- 3-5 days of life
- 1 month of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15 months of age
- 18 months of age
- 24 months of age
- 30 months of age
- 3-21 years of age – on a yearly basis

We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our children. Failure to do so may result in being discharged from the practice. We request that *only* primary caregivers bring children in for well checkups.

_____*(initial)* Appointments will be provided in a timely manner

All routine new and established patients are accommodated within five days; all urgent appointments for established patients will be attempted to be scheduled on a same-day basis if requested prior to 2:00 p.m., and on a next day basis if requested after 2:00 p.m., unless the family prefers another appointment.

_____*(initial)* Mutual Respect of Time

We pride ourselves on punctuality at One Family Pediatrics. Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. We may have to reschedule or squeeze you in whenever there is space if you arrive more than 15 minutes late.

2. If you plan on having an additional child seen during an appointment, please notify us in advance so that we can provide sufficient time with you.

3. We will provide you with all of the time that you need, but you must tell us when making the appointment ALL of the reasons you would like your child to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.

4. If you are running late, call the office. We may be able to accommodate you with advanced notice.

_____*(initial)* Confirm Appointment

Confirmations will be sent via email, text, and phone. If you do NOT confirm your appointment in at least one manner, we will assume you are out of the country or unavailable and will automatically cancel said appointment on the scheduled date.

OneFamilyPediatrics

Financial Policy

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

_____***(initial) Patient Balance is billed on the 5th of each month***

Patient balances are billed on the 5th of each month. Your remittance is due by the end of the month. Any account balance outstanding longer than the end of the month will be paid with the credit card on file (see below). If there is no contact made to the office about a payment plan and credit card is declined, the account will be charged a **$30** re-bill fee for each monthly cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency. If the account is sent to collections, a **50%** of balance collection fee will be added.

_____***(initial)*** **Self-pay accounts/Out of Network Insurance**

If you do not have insurance, please come prepared to pay for your visit in full. We offer a 30% discount for all self-pay services paid in full on the day of the visit. If payment cannot be made in full at time of service, a budget agreement can be made to have the service paid within 90 days with the first payment payable the day the service is rendered.

If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

_____***(initial)*** **Copays**

We are required by our insurance contracts to collect all co-payments at the time of service. Failure to collect co-payments puts the responsible party and One Family Pediatrics in default of the insurance contract. A **$25** service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.

_____***(initial)*** **Missed Appointment Fee**

Broken appointments represent a cost to us, you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Appointments not cancelled 24 hours in advance will result in a "No Show" fee of **$75** and may result in dismissal from the practice. This fee must be paid before a new appointment is scheduled. Patients with ***three*** missed appointments in a twelve-month period will be asked to transfer their records to another practice. Your child's appointment time will be confirmed via an automated email, phone or text. If you do not confirm the appointment within 24 hours, we will cancel your appointment and request that you reschedule to a later time.

_____***(initial)*** ***Returned Checks***

A **$50** fee will be charged for any checks returned for insufficient funds.

_____***(initial)*** **Georgia Medicaid Insurance Policy (Medicaid Only)**

If your child has Georgia Medicaid (Medicaid/Peachcare, Wellcare, CareSource or Amerigroup) and is also covered under a private health insurance, we are required by law to file claims with the private insurance policy first. Georgia Medicaid plans are **always** considered as secondary insurance.

If Georgia Medicaid is not informed that your child also has private insurance, they have the right to retract payment from previously paid claims. If this occurs, then the entire balance will be the **responsibility of the parent/guardian on file**.

PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

One Family Pediatrics Credit Card on File Policy

One Family Pediatrics requires that a valid Credit Card be kept on file.

The policy is designed to:

- Help avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts
- Focus our time and energy on your children and their medical care

The card information is stored electronically in an encrypted form and **cannot be viewed by our office staff.** Your signature will authorize the card to be used **only** when your balance becomes past due.

How the policy works:

1. At the time of your registration or check-in, you will be asked for your credit card information to be electronically stored in encrypted form in our computer. Only the last four digits are visible to our staff.
2. We will bill your insurance carrier as a courtesy for all charges related to the visit.
3. When we receive an explanation of benefits (EOB) form your insurance, we will send you a statement on the 5th of the following month, or the next business day after the 5th. If we have not received payment by the end of the month, we will charge the credit card on file for the balance due (on statement).
4. If we attempt to use your card and it is declined or has expired, we will send you a new statement with a note attached asking for current credit card information.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our office ASAP. If a mistake has been made, we will reverse the charges.

I have reviewed a copy of One Family Pediatrics Office, Financial and Credit Card on File Policies. I agree to provide my credit card information to One Family Pediatrics for the sole purpose of payment for my child(ren)'s medical care. I have the right to cancel this process and use another form of payment.

_____ _____
Signature of Authorized User Date

_____ _____
Print Name as it appears on your credit Card Phone # of Cardholder

Until further notice, I _____ authorize One Family Pediatrics to charge the patient-responsible balances on my account to the following credit card:

Credit Card #: _____ Expiration date (mm/yy): _____

Security code: _____ Card type (circle one): Master Card Visa Discover American Express