431 Southwest Blvd. N., St. Petersburg, FL 33703
727-526-PEDS (7337)

FINANCIAL AND OFFICE POLICIES

Patient Name: _____ Date of Birth:_____

Thank you for choosing Northeast Pediatrics for the care of your child/children. We welcome you to our practice and are here to serve you. We are committed to providing compassionate and competent pediatric health care. You will receive one of a kind health care experience from the front desk to the doctor's visit. You will be greeted with friendly faces, seen by well qualified nurses, and examined by only board-certified pediatricians. WELCOME!

BASIC POLICIES: Please initial each paragraph acknowledging you agree and understand each policy.

____ **INSURANCE**: Please be prepared to provide a copy of your insurance card at every visit. As a courtesy, we will bill your insurance carrier for you if proper paperwork is provided. Your insurance policy is a contract between YOU and the insurance company. The agreement is private, and we are not party to the contract. If services are not covered, we will have to bill you directly. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for the care provided. If an insurance carrier has not paid within 60 days of invoice billing, the amount will be your responsibility and will be payable in full by you. If you insurance carrier changes, you MUST notify us immediately. If new insurance information is not provided within 2 weeks of a visit, you will be financially responsible for the visit.

____**NONCOVERED SERVICES**: Please be aware that some services we provide may be non-covered services or are not considered necessary or reasonable under your policy but have been deemed medically in the best interest of your child by the physician. Any care not paid by your insurance will require full payment upon notice of claim denial. Periodic preventative health services may or may not be covered under you health care policy or may have annual limits. Our office follows American Academy of Pediatric well visit schedule and requires all patients follow that schedule. Any care not paid by insurance carrier will be your responsibility and payable in full by you.

____**CO-PAYS**: All co-pays are due in full on day of service, regardless of who has brought child to appointment (grandparents, a divorced parent who does not hold insurance policy, etc). Your CO-PAY is your contractual responsibility agreed upon by you and your insurance company. Your insurance company requires you to pay that portion at EVERY VISIT, and we incur billing expenses if not paid at that time. If a co-pay is not paid at time of service, there will be a $10.00 billing fee added to the invoice.

____**PAYMENTS**: If you have a balance due on your account, you will receive a statement from our office. However, your first statement IS the insurance company EOB (Explanation of Benefits). If no payment is received within 30 days of our statement, you will incur postage and late fees. If your account is past due 60 days, there will be a $25.00/month charge late fee, and you will be responsible for any collection agency or attorney fees that may occur.

____**RETURNED CHECKS**: If we receive a returned check from your bank due to insufficient funds or closed account, you will be charged a $30.00 fee. This fee and account balance will be due prior to next appointment.

____**NO SHOWS/CANCELLATIONS**: If you do not show up for your appointment or give us a 24 HOUR NOTICE of cancellation of appointment, there will be a $25.00 fee for sick visit and $50.00 fee for a well visit. Remember we have provided you with an appointment slot that could have been given to someone else. Emergencies will be considered case by case basis and only one waiver per family will be considered. Northeast Pediatrics will send appointment reminders via phone, email, or text as long as we have your updated information on file. Please realize this reminder service is a courtesy, and it is still your responsibility to keep your scheduled appointment.

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____**PHONE ADVICE**: If you call and receive phone advice from a physician, there will be a telephone consultation invoice sent to your insurance carrier. We are legally required to document any medical advice given. There will be no charge if the phone advice is followed up with an office visit within 3 business days for the same complaint, or the phone advice was related to a previous visit of the same problem within the last one week. Phone call consultations do take away from the physician's time during office hours and afterhours. This policy is supported by both the American Academy of Pediatrics and The American Medical Association.

____**FORMS**: There will be a $25.00 charge for paperwork such as FMLA papers, homebound forms, etc. Payment will be collected at the time our office receives the paperwork. Please allow at least 3 business days for completion. Physical and vaccine forms will be available upon request at each well visit without additional charge. If you require additional copies (for camps, multiple schools, those on alternate vaccine schedules), there will be a $10.00 charge per form.

____**MEDICATION REFILLS**: Medication refills for ongoing medications will be provided without charge if within 3 months of a visit. We do require every chronic medication need be followed up with an office visit every 3 months. No medication refill will be given afterhours. Please allow at least 2 business days to process refills.

____**VACCINES**: Our office does require our patients to follow a vaccine schedule. We strongly recommend following the CDC schedule. However, we will offer a separate vaccine consultation appointment for those who would like to have an honest informative discussion with the physician to create a vaccine schedule. We will accept patients on an alternative schedule as long as the schedule has a goal for complete immunization. You will have to sign a waiver for any alternative schedule. Please be aware if you intend on not vaccinating or fail to follow the agreed upon schedule, we will ask you to seek a new pediatric office, as we want to protect all our infants and immunocompromised children at risk from vaccine preventable diseases.

____**WELL VISITS**: We follow American Academy of Pediatrics well visit schedule. If you fail to follow the schedule, we will ask you to seek a new pediatric office, as we are dedicated to providing the most thorough and excellent care for your child.

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read, understand, and agree to the above office policies. I hereby request and give permission and full consent for "Northeast Pediatrics" (physicians and staff) to provide care and treatment for my child. I will notify the office of any change to this information or permission.

Parent/Guardian Name_____

Parent/Guardian Signature_____ Date_____