PATIENT POLICIES

FOR

Palmetto Pediatrics of Conway, Inc.

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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 read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) Our office hours are as follows: MONDAY-THURSDAY 9:00 to 12:00 and 2:00 to 5:00pm. On FRIDAYS, we close at 4:00 pm.
2) We will be available on Saturdays at 10:00 am for sick visits only. *You will need to be here at 10:00 as we see patients on a first come, first served basis.*
3) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. If you no show for more than 3 appointments, you may be discharged from the practice.
4) We encourage parents and caregivers to call ahead for scheduling of same day visits! Same-day sick appointments will be made in the first AVAILABLE slot. This will help the staff and physicians minimize any unnecessary waiting for families. Walk-ins will be seen as soon as possible, but appointments and call-ins will be seen first!
5) If you are late for your appointment (>15 minutes), it may be necessary to reschedule your appointment.
6) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
7) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
8) Holiday closings will be posted on our door or our telephone voicemail, please feel free to call in advance for information. There may also be times during the summer and holidays when our office hours are adjusted slightly.

Initial: __________

Insurance Plans

1) All patients will need to bring all current insurance cards/information and be prepared to pay their deductible, co-pay or percentage at each visit. Payment plans are available and prior arrangements can be made upon parent's request.
2) It is your responsibility to understand your benefit plan with regard to covered services, particularly coverage for vaccinations.

Initial: __________

(over)

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 participates in your plan.
3) Remember, we must approve referrals before they are issued.

Initial: ___________

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) Co-payments and any estimated coinsurance are due at the time of service.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit. We do offer a 50% discount for self-pay patients.
4) For scheduled appointments, prior balances must be paid or payment arrangements verified prior to the visit.
5) We accept cash, checks, Visa, MasterCard, and Discover.
6) A $30 fee will be charged for any checks returned for insufficient funds.

Initial: ___________

Prescription Refills

1) For monthly medication refills, we require 48 hours notice, during regular business hours. Please plan accordingly.

Initial: _____________

Transfer of Records

1) It is our desire to be your child's sole healthcare provider. Once a Release of Medical Records has been completed with your signature and records are transferred to another PRIMARY CARE PHYSICIAN, that child is no longer considered a patient in this practice. It is our policy that we do not accept these patients back once records have been sent to another local physician.

Initial: _____________

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)____

Responsible Party Member's Name ________________________Relationship_____________

Responsible Party Member's Signature ______________________ Date _________________

A copy of these policies will be provided to you for your reference.