UPTOWN PEDIATRICS

FINANCIAL POLICY

We will file your insurance for you, however, you are ultimately responsible for your charges.

1)Please bring your insurance card and photo ID to each visit

2)All co payments and percentages are due at the time of service, as per our contract with your insurance carrier.

3)If we do not participate with your insurance or you cannot provide us with the information needed to file, payment is expected in full at the time of service.

4)Not all services are covered by all insurances and may result in a patient balance. Please be familiar with your policy guidelines. If there are questions, you may call your insurance company directly before services are rendered. Some of the studies that may not be covered by your insurance are as follows, but not limited to:

a)Vision and hearing screening as part of the physical

b)developmental testing

c)HPV vaccination

d)urinalysis when done as part of a physical

e)hemoglobin when done as part of a physical

f)Rocephin and Decadron injections

g)fingerstick glucose

h)lead test when done as part of physical

We feel that these services are not only medically necessary, but also essential to ensure we are continuously providing exceptional customer service.

5)It is your responsibility to notify our office prior to any service of any insurance changes.

6)In the event of divorce or separation, we will provide you with a receipt of copay/deductible/% of charges, etc. You are still responsible for payment at the time of service.

APPOINTMENTS

1)Your appointment time is specific for you. If you arrive late for your appointment, you may be asked to reschedule your appointment. If you need to cancel your appointment, please try to call 24 hours in advance.

2) If you are a "no show" for your appointment 3 times, we reserve the right to discharge your children from this practice. A "no show" is considered if you do not call; do not show for the appointment; or arrive late for the appointment. For any of these circumstances, you will be charged a fee that is not covered by insurances. You will also receive a warning notice after each "no show" appointment.

2)We will have some open slots each day for sick children. Please call ahead, as we will no longer accept "walk ins".

3)We try to have a person answer each call, however, at times, it will be necessary for our automated message to respond. We have many options for you to choose. It is our responsibility to retrieve those messages and respond as quickly as possible. It is your responsibility to leave adequate information for the call back. If there is a no answer, we will leave a message for you. Please listen to that message before calling us back.

OFFICE ENVIRONMENT

Our providers and staff strive to provide a clean, safe, and pleasant environment for your childs care. We ask that you respect our staff and other families during your visit. We will not tolerate disruptive, threatening, or destructive actions/behavior (eg, littering, profanity, etc.) Please refrain from touching the computer, tvs, and /or medical equipment. We reserve the right to refuse treatment and/or dismissal from our practice if warranted.

FORMS

1)An immunization form will be provided to you at the time of your child's well check appointment. Replacement forms will be assessed a fee of 5.00 per form.

2)FMLA forms are assessed a charge of 25.00. Please allow for 1 week for completion.

3)Letters written at the request of the parent are also assessed a fee. That fee will vary depending on the content of the letter. Please allow for 1 week for the completion of the letter unless lengthy research is necessary.

CONSENT TO TREAT

We follow the guidelines of the American Academy of pediatrics in the treatment recommended for your child/children. IMMUNIZATIONS WILL BE ADMINISTERED AS RECOMMENDED by the American Academy of Pediatrics and the Centers for Disease Control. If there are any question regarding this policy, those questions should be addressed before the child/children are triaged.

PATIENT CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

With my consent, Uptown Pediatrics may use and disclose protected health information (PHI) about my child to carry out treatment, payment, and healthcare operations.

I have the right to review the Notice of Privacy Practices in full prior to signing this consent.

With my consent, Uptown Pediatrics may call my home, or other designated location and leave a message about my childs clinical care. If there are any restrictions regarding this, the parent/guardian is responsible for notifying us in writing. Listed are approved persons to receive information about my child:

SIGNATURE PAGE

Childs name_____

1)_____2)_____

3_____4)_____

Last 4 digits of each persons SS# to be used as confirmation of identity

1)_____2)_____3)_____4)_____

Each of these persons will be asked for this information prior to any discussion. Please make them aware that we will be asking for this information.

By my signature, I am giving consent to Uptown Pediatrics to disclose my child's PHI to carry our healthcare treatment. By my signature, I also acknowledge that I have read and understand all of the policies.

_____ _____

Signature of parent or guardian Date

Name of child