The Whole Child Center Office Policies

Patient Name: _____ Patient DOB: _____

Financial Responsibility

- If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit, unless other arrangements have been made in advance.
- If we do participate with your insurance, co-payments are due at the time of service. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due upon your receipt of your bill.
- If previous arrangements have *not* been made with our office, any account balance outstanding longer than 90 days will be forwarded to a collection agency.
- For scheduled appointments, prior balances must be paid prior to the visit.
- A $50 fee will be charged for any checks returned for insufficient funds.
- As of January 1 of each calendar year, you are responsible for the annual fee. The fee is $150/year for one child, $250/year for two children and $350/year for three or more children. Families with twins or triplets qualify for a discount as arranged with our office manager. This fee specifically covers services not covered by your medical insurance. If you do not pay the fee by January 31, you will be put into inactive status and will not be able to schedule appointments until the fee is reconciled. This fee is non-refundable.

Insurance Plans

- It is your responsibility to keep us updated with your correct insurance information. If the insurance information you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- If we are your primary care physician and we participate with your insurance, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit. It is your responsibility to make sure we participate with your insurance plan at the time of service.
- It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories.
- It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Referrals

- Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
- It is your responsibility to know if a selected specialist participates in your plan.

Appointments

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice. There is a charge of $100 for missed pre-scheduled appointments. Prices are subject to change.
- Please arrive on time for your appointment. If you are more than 10 minutes late, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Transfer of Records

- If you transfer to another physician, we will provide one copy of your medical record, free of charge, as a courtesy to you, if you pick it up in person or we can fax to the physician's office. To mail records, we will charge mailing costs in excess of $10. We need 24-48 hours' notice to prepare records.
- We provide records of your child for visits (including consultations from specialists) rendered here at the Whole Child Center only. For any previous records, you must request them directly from your previous doctor(s).

Prescription Refills

- For monthly medication refills, we require 24-48 hours' notice, during regular business hours. Please plan accordingly. These can be requested on-line or by phone.

Authorization to Leave Messages in my Absence

- I give The Whole Child Center or its proxy permission to leave a message on my answering machine regarding appointments or other administrative concerns, in my absence. We will not leave a message with protected health information.

Consent to Treatment

- I consent to general treatment, medical procedures, and medications prescribed by practitioners at The Whole Child Center. I understand my child may be scheduled with any available physician or Nurse Practitioner.

Acknowledgement of Receipt of Notice of Privacy Practices

- I acknowledge receipt of a Notice of Privacy Practices from The Whole Child Center.
- I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

I have read and understand the above policies, and I agree in full to these terms.

Responsible Party's Name/Relationship _____
Responsible Party's Signature/Date _____