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Office Policy

****Please initial on each line****

Well Check-ups are Required

At Firefly 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
- ❖ 3-23 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 patients. Repeated failure to do so may result in being discharged from the practice. We request that *only* primary caregivers bring children in for well checkups. Please be aware that it is your responsibility to check with insurance to verify well visit coverage and how often they are covered.

Mutual Respect of Time

We pride ourselves on punctuality at Firefly 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, please call the office. We may be able to accommodate you with advanced notice.

Payment is required at the time services are rendered

This includes co-payments and payments for services not covered or denied by the insurance company. If you participate in a High Deductible Insurance plan, we require a minimum of a \$70 payment at the time of service. Whichever parent or caregiver brings the child to the appointment is responsible for making this payment. Should your balance be overdue for more than 60 days, you may incur a \$25 per month charge for each month the balance remains outstanding. This charge will be waived if you are making scheduled payments on a payment plan.

Please turn over and fill out back of page.

_____ **Self-pay accounts**

If you do not have insurance, please come prepared to pay for your visit in full. 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.

_____ **Copays**

We are required by our insurance contracts to collect all co-payments at the time of service. Not doing so is a violation of our contract with your insurance company, therefore we cannot “waive” or “bill” copays.

_____ **Missed Appointment Fee**

Missed 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 48 hours prior to the appointment. Appointments not cancelled 48 hours in advance will result in a “No Show” fee of \$50. This fee must be paid before a new appointment is scheduled.

I have read the Office Policy as outlined above and understand the consequences. I also understand that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian.

Firefly Pediatrics accepts cash, debit cards , Visa, Master Card, and Discover, as well as HSA cards.

PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency, the undersigned shall pay all collection agency fees, court costs and attorney fees, and risks being dismissed from the physician care of Firefly Pediatrics.

By my signature below, I authorize the release of information necessary to file a claim(s) with my insurance company(ies) and assign benefits otherwise payable to me, to the provider, or the group indicated on the claim. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the full payment or balance as allowed on my account. I understand that co-payments, deductibles and payments for services not covered or denied by the insurance company are due at the time of service. I understand that if my account goes to collections, I shall pay all collection fees and costs incurred by Firefly Pediatrics. I certify that this information is true and accurate to the best of my knowledge and will notify the office of any changes to my information, such as, but not limited to change in address, telephone numbers, insurance coverage, custodial relationships, etc. I have read, understand, and agree to abide by the Financial Policy.

Name of Patient(s): _____

Guarantor Name: _____

Guarantor’s Signature: _____ Date: ____ / ____ / _____