# Office Policy

***Please initial on each line***

## **"Anyone under the age of 18 must be accompanied by an adult."**

_____ **(initial) Well Check-ups are Required**

At Columbus Pediatric Associates, 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<br>❖ 3-5 days of life<br>❖ 1 month of age<br>❖ 2 months of age<br>❖ 4 months of age | ❖ 6 months of age<br>❖ 9months of age<br>❖ 12 months of age<br>❖ 15 months of age<br>❖ 18 months of age | ❖ 24 months of age<br>❖ 30 months of age<br>❖ 3-18 years of age – on a Yearly bases |

*We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our children.* Failure to do so may result in being discharged from the practice.

______**(initial) Mutual Respect of Time**

We pride ourselves on punctuality at Columbus Pediatric Associates. 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 request:

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, call the office. We may be able to accommodate you with advanced notice.

Patient Name: _____________________________________ Dob: _______________________

Patient Name: ______________________________ Dob: _______________________________

______ **(initial) Credit Card on File Policy**

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. As a result, we require that all patients need to have a credit or debit card number on file with our office. Please be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

**Columbus Pediatric Associates accepts cash, debit cards, HAS cards, Master Card or Visa.**

______ **(initial) Payment is required at the time services are rendered**

This includes applicable coinsurance, co-payments for services not covered or denied by the insurance company.

______ **(initial) 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 pain within 60 days with the first payment payable the day the service is rendered with a credit card left for future payments.

______ **(initial) Copays**

We are required by our insurance contracts to collect all co-payments at the time of service as well as any outstanding balance. Failure to pay co-payments will result in a $20 billing fee not billable to insurance.

______ **(initial) Confirm Appointment**

Confirmations will be sent via text. List preferred confirmation Cell # __________________. Please confirm by text. The text will come from a number beginning with 62.

______ **(initial) Missed Appointment Fee**

Broken 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 24 hours prior to the appointment. This fee must be paid before a new appointment is scheduled. Patients with ***three*** missed appointments in a twelve-month period will be asked to transfer their records to another practice.

**Columbus Pediatric Associates accepts cash, debit cards, HSA cards, Master Card or Visa.**

______ **(initial) for Medicaid only) Georgia Medicaid Insurance Policy (Medicaid Only)**

If your child has Georgia Medicaid, (Peach state) and is also covered under a private health insurance, we are required by law to file claims with the private insurance policy first. Georgia Medicaid / Peach state plans are **always** considered as secondary insurance unless the appointment is for a health check wellness exam.

If Georgia Medicaid is not informed that your child also has private insurance, they have the right to retract payment from previously paid claims. If this occurs, then the entire balance will be the **responsibility of the parent/guardian on file.**

By signing this notice, you acknowledge receipt and understanding of the Office Policy as outlined above and understand the consequences. You also understand that you are ultimately responsible for the charges incurred by your child / children as their legal parent or guardian.

**PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT**

**Signature of Parent / Guardian:** ________________________ **Date:** _____________