DAILEY PEDIATRICS + family medicine

FINANCIAL AND PRACTICE POLICIES

Please read and initial beside each column:

Initials	Policy Number	Policy
	1	Emergencies: Our providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response, please call 911 or to the nearest emergency room.
	2	Refills: It is our policy that the patient should be responsible to know when medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through the patient's pharmacy (this includes mail order prescriptions). Phone calls for refills should be directed to your pharmacy.
	3	Sick Patients:Patients with acute illnesses will be seen within 24 hours of the next business day if possible. There may be circumstances where our office is closed and we can direct you where to be seen for sick visits in the event our office is closed.
	4	Personal Information: You agree to provide your correct name, current and correct address, home and cell number, insurance information(if applicable), social security number, driver's license, or picture identification at the time of registration or as requested by tho practice at any time.

	5	Financial Responsibility: By providing your initials and your signature below, you accept financial responsibility for ALL charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes the liability. ALL PAYMENTS ARE DUE AT TIME OF SERVICE.
	6	Payment Methods: We accept cash, check, Visa, Master and Discover credit cards.
	7	Appointments: Our office will schedule appointments as the patient calls/requests in the most time efficient manner possible. Minors must be accompanied by a parent or guardian to be seen in our office. We require a minimum of 24 hours notice of cancellation as a courtesy. A fee of $45 will be charged at our discretion for same day cancellation and no show appointments for established patients. New patients who fail to cancel will be billed $125. A pattern of non-cancelled missed appointments may result in being discharged from the practice. If You are more than 15 minutes late, your appointment may be rescheduled to another time or date if unable to be worked in.
	8	Fees: Our practice charges for additional paperwork outside of the completion of the medical record. A $20 fee will be charged for forms that must be completed and signed by a doctor.
	9	Medical Records: The medical chart is property of the practice. However, copies of your pertinent information are available upon request. We request that you allow at least one week notification when requesting a copy of your medical record.
	10	Insurance Copayments, Deductibles, and Coinsurance: At this time, we are a cash only Practice. All charges are due at time of service. You may request a copy of your statement of fees paid at time of visit for you to provide to your insurance company so that it may go towards your deductible and you also be eligible for reimbursement from your insurance company. If you are unable to pay full amount at time of service, please let our staff know and we can work out an arrangement.
	11	Accident and Worker's Compensation: Although our office will be happy to treat your medical condition if it is within our means of treatment, If the cause is related to an auto or work related

		accident, you will be required to pay the full fees at the time of your visit.
	12	Collection and Bank Fees: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expenses, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.
	13	Patient Discharge: The practice reserves the right to discharge a patient for any reason. Please note that discharge may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plans as outlined by your Medical Provider.

I have read and understand the terms of this policy and by my initials and signature below, latest that I fully understand each item and agree to the above terms.

Printed Name:_____

Signature: _____

Date:_____