<u>Appointment and Financial Policy Pediatric Health Center</u>

Purpose: This policy will govern our scheduling and cancellation of appointments. We hope this will eliminate scheduling issues and limit the wait time in our office.

- We pride ourselves in our 30 minute waiting room time. We accomplish this by proper staffing, timely scheduling, and organization.
- If your wait time is longer and we are not verifying insurance or there is no apparent reason, such as an emergency, please remind our patient coordinator how long you have been waiting.
- Since we work by <u>**APPOINTMENTS ONLY**</u>, notice must be given <u>in advance</u> to cancel an appointment in order for it not to be considered a "No Show".
- A **$40.00** office charge fee will be billed to you if you "**no show**" as explained above. If you are insured through by Peachcare, Medicaid or CMO, you must cancel timely or you will be given a warning. After 3 or more “no shows” you may be asked to find another pediatrician.
- We reserve the right to charge for after hours phone calls if it pertains to a new illness. There is a **$5** charge for the state immunization form if it is not requested at the time of your well visit.
- You will be notified by phone or mail and we will attempt to reschedule at your convenience. A patient **arriving late** will be seen after all other scheduled appointments, or if extremely late, you will be **rescheduled** to another day. Our Appointment Scheduler verifies all appointments the day before a previously scheduled appointment. If confirmation is not made, your appointment may be rescheduled.
- Occasionally, when a checkup is scheduled, the patient will also be sick. We reserve the right to charge for a brief sick visit if there is need to spend extra time. You, of course, have the right to be seen for the sick visit only and/or reschedule the checkup. The doctor recommends this for all complex illnesses.
- All co-pays and any other fees for which you are responsible are paid at check out on the same day as service unless other arrangements have been made prior to the visit. There is a **$25 fee** for all **returned checks.**

Thank you in advance for your consideration and understanding.
PEDIATRIC HEALTH CENTER MANAGEMENT

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Parent’s Signature Date

I have read the above and fully understand the policy.

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