Tree House Pediatrics, PLLC

Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) 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 a 24-hour notice. **There is a $40 fee for missed appointments.**
2) If you are late for your appointment (**>10 minutes**), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
5) Children **must** be supervised by parents at **all** times.
6) Please keep our office clean by picking up after your child. Please do not allow your child to damage or deface our office and furnishings.

Initial: _____

Insurance Plans

Please understand

1) We must emphasize that as pediatric providers, our relationship is with **you,** not your insurance company.
2) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for the payment of the visit and to submit charges to the correct plan for reimbursement.**
3) If we are your primary care physician, make sure our name or phone number appears on your card. If you insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
4) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example:
    a. Not all plans cover annual healthy (well) physicals, sports physicals, vaccinations, or hearing or vision screenings. If these are not covered, you will be responsible for payment.
    b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
5) It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3-5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) In general, we will not agree to a referral for a problem we have not been consulted about first.

Initial: _____

After Hours Nurse Calls

1) After hours calls should be reserved for true emergencies. Callers will reach a voice message which gives them the opportunity to reach the nurse service. **If you choose to speak with a nurse, the service fee is $20 per call.** If your child needs to see a doctor after hours, we recommend Nite Lite Pediatrics or the ER.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances.
2) Co-payments are due at the time of service.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 14 business days of receipt of your bill.
5) If previous arrangements have **not** been made with our billing department, any account balance outstanding longer than 28 days will be charged a $5 bill fee for **each** 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
6) All outstandng balances must be paid and will be collected upon arrival.
7) We accept cash, checks, Visa and Master Card credit and debit.
8) A $50 fee will be charged for any checks returned for insufficient funds.
9) The accompanying parent or adult is responsible for full payment at the time of service. In the case of separation/divorce/discord, please do not place our office in the middle of family disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We realize that temporary financial problems may affect timely payment of your account.
10) If financial problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Forms

Initial: _____

1) There is no charge for immunization and physical forms given at the time of your child's visit. This is considered part of the visit. **However,** should you lose your forms, there will be a $10 fee ($5 per form) to replace them.
2) Any additional school, camp, or sports forms are subject to a $5 fee, per form. Family Medical Leave Act forms are $35. Payment is due when the forms are dropped off. We require a 3 day turnaround time.

Initial: _____

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge. We will need 48 hours.
2) A copy of your complete record is available for a fee of $1 per page for the first 25 pages and then .25 per page after that, per Florida State law.
3) We provide records of your child for visits (including consultations and specialists) rendered here at Tree House Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

Prescription Refills

1) For medication refills, we require a 48 hour notice, during regular business hours. Please plan accordingly. Antibiotics will not be refilled.
2) For ADD and ADHD medication refills, quarterly evaluations are required by Florida law. It is your responsibility to schedule these visits well in advance, to insure refill requirements have been met.

Initial: _____

I have read and understand these office policies and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name: _____

Responsible Party Member's Name: _____

Relationship: _____

Responsible Party Member's Signature: _____

Date: _____

Tree House Pediatrics

10743 Narcoossee Rd. Suite A-13

Orlando, FL 32832

P: 407-736-8733 F: 888-974-1815

Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Information requested FROM:

Doctor: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

(Phone number or address are greatly appreciated.)

Information to be disclosed (please specify with a check mark):

____ Shot Records ____ Growth Charts

____ 3 Previous Office Visits ____ Most Recent Physical Exam

____ Psychiatric/HIV/Drug Use History

____ Entire Record (if your child has complex medical issues)

Purpose of disclosure (please specify with a check mark):

____ Changing Physician ____ Further Medical Care ____ Personal Copy

This authorization for release of health information will be valid for one calendar year from the date of signature. It may be revoked at any time in writing.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Information/Update

Patient's Full Name: _____

First Middle Last

Patient's Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ (Home or Cell, please circle)

Patient's Date of Birth: _____/_____/_____ Male: _____ Female: _____

Ethnicity: Not Hispanic _____ Hispanic _____ Prefers not to answer _____

Preferred Language: English _____ Spanish _____ Other _____

Race: American Indian _____ Asian _____ Black/African American _____

Native HI/Pacific IS _____ White _____ Prefers not to answer _____

Guardian Information

Mother's Full Name: _____

First Middle Last

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Date of Birth: _____

Mother's SS#: _____-_____-_____ Driver's License #: _____

Mother's place of employment/occupation: _____

Workplace phone number: _____ Ext: _____

Father's Full Name: _____

First Middle Last

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Date of Birth: _____

Father's SS#: _____-_____-_____ Driver's License #: _____

Father's place of employment/occupation: _____

Workplace phone number: _____ Ext: _____

Emergency Contact Information

(Other than parent/guardian)

Name of person to be contacted in case of emergency or has authorization to make medical decisions on your behalf.

Name: _____

Relationship: _____

Address: _____

Phone (home/work): _____ Cell: _____

Insurance Information

Insurance Carrier/Plan: _____ Phone: _____

Claims Address: _____

Policy Holder's Name: _____ Date of Birth: _____

Is this plan provided by your employer? _____ Yes _____ No

Place of Employment: _____

Type of plan: _____ HMO _____ PPO _____ Other

ID Number: _____ Group Number: _____

Effective Date of Coverage: _____/_____/_____

Amount of Deductible: $_____ Amount of Co-payment: $_____

Are well child examinations AND immunizations covered benefits in your policy?

_____ Yes _____ No

The accompanying parent or adult is responsible for full payment at the time of service. In the case of separation/divorce/discord, please do not place our office in the middle of family disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We realize that temporary financial problems may affect timely payment of your account. If financial problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Patient Portal Enrollment Form

Patient Name: _____

First Middle Last

Date of Birth: _____ (*If the patient is 15 years of age or older they MUST set up their own portal account.)

By signing this form you agree to have access to Tree House Pediatrics Patient Portal and are solely responsible for keeping your username and password safe and secure.

Parent/Guardian (For patients under 15 years of age)

Name: _____

First Middle Last

Email Address: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____

Date Signed: _____

***When the patient turns 15 years of age, Parent/Guardian access will be disabled. The patient will need to fill a new enrollment form out and be set up with their own account. We follow all HIPAA STATE AND FEDERAL LAWS which requires us to protect some patient health information starting at age 15.**

Patient (for patients 15 years of age and older)

Email Address: _____

Phone Number: _____

Patient Signature: _____

Date Signed: _____

(For office use only)

Received by: _____

Date Registered: _____

Staff Initials: _____