WHOLE CHILD Pediatrics

WHOLE FAMILY Integrative Health

Policy and Procedure

Our offices would like to welcome you to our family of physicians and healthcare providers. Thank you for choosing us to care for you and your loved ones, we are committed to your healthcare. This Policy and Procedure statement is intended to answer common questions about our practice.

While we hope to maintain a longstanding relationship, we must ensure all patients follow our policies. We require all patients and or parent/guardians to read and sign this statement which will be kept in each patient's chart. Failure to adhere to these policies can result in dismissal from the practice. **Please initial each line, acknowledging the policy, and fill out the back of the form completely**.

Annual Physicals _____

We require all active patients in our practice to have an annual physical. We believe an ongoing relationship must be maintained in order to provide you with the best healthcare possible. If you have not had a physical with our practice in the last year, we will not be able to dispense any medical advice, or refill any medications. We want you to create an ongoing relationship with our providers to best serve your health needs.

Payments for Service

We accept Visa, MasterCard, AMEX, and Discover, debit cards, money orders, personal checks, and cash. Starter checks and postdated checks are not accepted. We require a valid ID with photo to write checks. If a personal check is returned for any reason, a $30 fee will be added to the original amount. After two returned personal checks we will not accept further payments by personal check. Co-payments, coinsurances and/or deductibles are to be paid at time of service.

Cancellation/No Show Policy _____

To ensure all patients have access to our medical providers, we have established the following fees for late cancellations and no shows. Office visits cancelled less than 24 hours in advance or on the day of the appointment (regardless of when scheduled) will be charged a fee based on the appointment type:

- 15 minute appointment charge of $25 (wellness, sick or physical)
- 30 minute appointment charge of $50 (new patient, allergy or complex)
- ADD/ADHD med check appointment charge of $75
- These fees are charged to the patient not the insurance company

Adjusted Rate/Self-Pay Patients

Whole Child/ Whole Family welcomes patients that do not have insurance coverage for our services. When this is the case we have predetermined fees adjusted according to the insurance industry. These fees are due at the time of service.

Insurance Coverage _____

If our services or providers are not covered under your insurance plan, the patient and/or guardian is responsible for payment of all charges. In some cases, your insurance may not cover certain services or may have coverage limits in place. If so, the patient and/or guardian are responsible for the charges. Limited coverage on routine, preventive healthcare is common. Please review your insurance plan. Please note, patients are responsible for all non-covered charges as well as what your insurance considers the patient's responsibility.

Late Fee _____

A late fee of $25 will be charged to your account monthly if payment in full or payment arrangements, with a credit card on file, have not been made or received within 30 days of the date on the statement.

Collections

If you, your spouse, or your dependent (s) account is delinquent for more than 121 days and goes to collections with either of our offices for any reason, you, your spouse and your dependent (s) will be discharged from the practice. A one-time service fee of $25, per account, will be added to your bill. Once discharged you will need to find alternative medical care with a new provider. We will not provide medical advice, prescriptions or office appointments once discharged from the practice for any reason.

Vaccinations _____

It is your responsibility to understand your insurance plan. If your vaccines are not covered by insurance you are responsible for the charges. If you choose to not vaccinate, there is a charge for vaccination counseling that is legally mandated at every well child visit. If you agree to a vaccination but change your mind after it has been prepared, you will be responsible for the cost of the vaccine, whether it is administered or not.

PLEASE TURN OVER 

Authorization to Release Information

I hereby authorize Whole Child/Whole Family to: (1) release any information necessary to insurance carriers regarding my or my dependents illness (s) and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Whole Child/Whole Family on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Medical Records

For Whole Child/Whole Family to release medical records from our offices, we must have a completed and signed release form. We charge a $25 flat medical records fee per person per request. If we are transferring records to another provider it will be done either at a per page price following Illinois law or the $25 flat fee, whichever is less. Please allow 7-10 days for those to be processed. Once you request your records to be sent to another primary care provider, you will no longer be able to receive services from our clinic including phone consultations.

Forms/Letters

Please allow 3-5 business days to fill out any form. A valid ID must be shown for us to release forms, prescriptions etc. If the person picking up the form is not the stated patient, their name must be listed on the HIPAA release form. We fill out school, sports/camp forms, asthma medication school forms and others during your child's office visit free of charge if the request is made at the time of your child's visit. If a request to complete a form occurs after your child's visit, a charge will apply:

IL School Form.....$15

Sports Participation Form.....$15

Camp Physical Forms.....$15

Asthma Medication Forms……$15

Medication in School Forms.....$15

School Excuse Notes…….....$15

Other Forms……$15

From time to time, parents need letters written and signed by the staff or the doctor on the practice's letterhead. Generally, these letters are not templates, thus require time to prepare and write. For such letters, there is a charge of $25. We will need at least 2-weeks to complete the letter.

HIPAA

We are required by law to maintain the privacy of protected health information and to provide patients with the notice of our legal duties and privacy practices with respect to protected health information. This notice is effective April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have the recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, regarding violations of the provisions of this notice or the policies and procedures of our offices. We will not retaliate against you for filing a complaint.

Assignment of Benefits

By signing this form, I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I authorize and direct my insurance carriers including Medicare, private insurance, and/or any other health/medical plan to issue payment(s) directly to Whole Child/Whole Family for services rendered to myself and/or my dependents, regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by my insurance.

If at any point you or a family member become verbally or physically abusive to our staff or providers, you will be asked to leave the premises, law enforcement may be called, and it could lead to discharge from the practice.

Patient Name

Date of Birth

Patient/Responsible Party Signature

Date