Louisville Pediatric
SPECIALISTS

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Office Policy

Our goal is to provide and maintain a good physician-patient relationship by making every visit a positive one for you and your children. We have designed our office policy with our patient's best interest in mind to allow for great communication and support. Please review carefully the policies outlined in this document and initial. If you have any questions, a member of our staff would be happy to assist.

Appointments

1) We value the time we have set aside to see and treat your child. Therefore, we have developed a scheduling system that allows us to see patients in the most efficient manner possible. We work hard to stay on schedule so that your wait time is minimal. If you are not able to keep an appointment, please notify us at least 6 hours before your appointment.

Failure to do so may result in a $50.00 no show charge on your account. This charge must be paid in full at the time of your next appointment.

In the event of three (3) documented "no shows/same-day cancellations," within that same 12-month time frame without proper notification to our office the patient, you may be subject to dismissal from Louisville Pediatric Specialists. The patient's chart is reviewed, and dismissals are determined by management only, no exceptions. If we choose to dismiss you, we will provide you with advance written notice to allow you enough time to find another provider.

2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, your appointment will be treated as a walk-in and can result in rescheduling your appointment. We do understand that emergencies occur and appreciate your understanding and willingness to adhere to these policies.

3) Before making an annual physical appointment, please check with your insurance company to ensure the visit will be covered as a well visit.

Initial: _____

Insurance Plans

Please understand

1) 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 payment of the visit and to submit the charges to the correct plan for reimbursement.

2) We do not know each patient's individual insurance plan. Therefore, it is the patient's responsibility to communicate with their individual carrier for covered services.

3) If your insurance carrier is requesting that you list the name of your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 7 business days.

2) It is your responsibility to know if a selected specialist participates in your plan.

3) Remember, we must approve referrals before they are issued.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. We are legally required to collect those at the time of service.

2) Any prior balance on your account will be collected at your current visit. Balances over $500.00 can be setup on a payment plan if needed.

3) Self-pay patients are expected to pay for services in FULL at the time of the visit.

4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 business days of your receipt of your bill.

6) Any balance outstanding greater than 120 days will be forwarded to a collection agency.

7) We accept cash, checks, HSA,Visa, and MasterCard credit and debit. We do not participate in debit to hold for copayments or coinsurance.

8) A $25.00 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms

1) There is a $10.00 charge for filling out any of the following:

- Physical Form
- Personal Letter
- Misc Forms needing Physician signature

2) There is a $25.00 charge for filling FMLA forms
All charges must be paid before we fill out the forms. We require 3-day turnaround time.
Initial: _____

Transfer of Records

1) If you transfer to another physician, we will provide one free copy of your medical records. Please provide at least 48 hours' notice.

2) We provide records of your child for visits (including consultations from specialists) rendered here at Louisville Pediatric Specialists only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

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

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____

----------Please ask for a copy for your records----------