



Seashore Pediatrics Policy and Procedures

OFFICE POLICY AND PROCEDURES

The following policies have been implemented:

1. At the time of check-in at EVERY visit, you will be required to provide your insurance card and identification (DL, State ID, Military ID or any legal ID). All insurance will be verified upon arrival. All deduction, co-pays, and/or coinsurances amounts will be due at the time of service.
2. If you are a new patient, please come to your appointment at least 15 minutes before the scheduled appointment to complete the registration process. As a new patient if you do not show for your first initial appointment you will not be accepted in our Practice.
3. Any routine call backs, prescriptions, or documents left for the physician will be completed within 24 hours.
4. At the time of service, if your account reflects an outstanding balance, you will be asked to pay the balance in FULL before you can check in.
5. There is a \$35.00 service fee for any returned checks. In addition, ALL expenses incurred to recover outstanding balances will be payable immediately (including but not limited to collection agency and legal fees).
6. In order to improve access to care for all patients, failure to cancel or reschedule an appointment by 3pm the day before your appointment, and/or failure to present at the time of the appointment, will result in a "no show". Once you have 4 "no shows" the patient will be released from our Practice.

Signature of Parent/Guardian: _____ Date: ____/____/____

INSURANCE POLICY

1. All insurance recipients must present their current insurance card at the time of service. If you do not have your insurance card you will be considered self-pay patient.
2. If you have insurance that is primary with Medicaid as secondary, you must provide this information at the time of service. If you fail to disclose your primary insurance, your claim will be denied.
3. Patient/Guarantor will be responsible for all charges incurred if no insurance card is presented or if any not paid or covered by their insurance. Services not covered by your insurance company will be due at the time of service. It is your responsibility to know what is covered and what is not.
4. Please notify our office if there are any changes in your insurance coverage or change of insurance carriers.

As a courtesy, Seashore Pediatrics will file your insurance provided but cannot guarantee payment. I hereby authorize Seashore Pediatrics to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Seashore Pediatrics.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

I acknowledge receipt of the privacy rights with detailed information regarding how Seashore Pediatrics may use and disclose my child's protected health information. I authorize Seashore Pediatrics to release my child's protected medical health information when contacting me by the phone, mail or email I provided on my child's registration form with appointment reminders, test results, account balance information and any other health related information pertaining to my child. This authorization will remain in effect unless revoked in writing.

I fully understand and have read the Seashore Pediatrics Office procedures, Insurance Policy and Notice of Privacy Policy and agree to abide by these policies.

Signature of Parent/Guardian: _____ Date: ____/____/____