

PEDIATRIC PARTNERS OF WINTER HAVEN

CLINIC POLICIES AND PROCEDURES

NAME OF PATIENT

DATE OF BIRTH

Thank you for entrusting the care of your child/children to Pediatric Partners of Winter Haven. To make your visit the best possible, we would like a couple minutes of your time to explain the office policies, **and ask that you comply with the policies so that we may provide the best possible service to you and your children.**

If an appointment is not cancelled/rescheduled 24 hours prior to your appointment time, you may be charged a **fee of \$40**. This is your liability and must be paid before your child is seen for any future appointment. **THIS IS DUE AND PAYABLE BY THE PARENT/GUARDIAN AND IS NOT BILLED TO THE INSURANCE COMPANY.**

IT IS THE POLICY OF THIS OFFICE THAT, AFTER THREE MISSED APPOINTMENTS WITHOUT 24-HOUR PRIOR NOTICE, WE MAY DISMISS ALL FAMILY MEMBERS. THERE IS ALSO A ZERO-TOLERANCE POLICY FOR CURSING AND RUDE/DISRUPTIVE BEHAVIOR. SUCH BEHAVIOR WILL RESULT IN YOUR DISMISSAL FROM THE PRACTICE.

It is very important that you arrive on time for your appointment. **IF YOU ARE MORE THAN 5 MINUTES LATE, WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT.**

If you are requesting any type of paperwork, school forms, shot records, etc., we require a minimum of 48 hours notice, and a fee may be required for these as well. These are items that must be done between patients, or at the end of the day. It is very difficult for us to do them immediately, if you just stop by the office. **WE WILL REQUIRE 48 HOURS.**

If you would like for someone other than yourself to bring your child for treatment, we **MUST** have the necessary release forms completed before the child can be seen. **We must have written permission in the chart by the LEGAL GUARDIAN of the child allowing permission for the child to be seen without you present OR WE WILL NOT SEE THE CHILD!** It is your responsibility to ensure that if someone else brings your child/children, they must have the insurance card and their photo ID, make sure the insurance is active, and that we are assigned as your primary care physician.

PLEASE TURN OFF ALL CELL PHONES AS WE HAVE A NO CELL PHONE POLICY!! IT IS YOUR RESPONSIBILITY TO LET ANYONE YOU HAVE CONSENTED TO BRING IN YOUR CHILD/CHILDREN AWARE OF THIS POLICY.

FINANCIAL: Please be advised that you are required to show a copy of your current insurance card and valid photo ID at EVERY VISIT. You are also responsible for any and all copays, deductibles, no-show fees, or visits deemed not covered by your insurance carrier. If your account goes to collections, you hereby agree that you are responsible for all additional legal fees as required by law. Please understand that we do not bill secondary insurance companies. **PEDIATRIC PARTNERS WILL ONLY BILL AS PRIMARY INSURANCE.**

SIGNATURE OF PARENT/GUARDIAN

DATE