**SuperKids Pediatrics Office Policies**

**9121 N Military Trail Suit 102, Palm Beach Gardens, FL 33410**

**Phone 561-619-2460**

**Office Policy**

Thank you for choosing SuperKids Pediatrics! We are excited to partner with you and provide your family with the highest care possible. It is within this context that we ask you to take a few moments to review our office policies. Our practice manager or provider will be glad to answer any questions or discuss any concern with you.

 **No show or late arrivals (considered >10 minutes after scheduled appointment).** I understand that a no-show charge for the lost appointment will apply and that the first-available appointment may or may not be on the same day the appointment was missed. I understand that patients who have arrived on time will be seen ahead of those who arrive late. Please call ahead if you are late or unable to make your appointment time. I UNDERSTAND THAT A $25 DOLLAR FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED AT LEAST WITH 24-HOURS ADVANCED NOTICE.

 **Appointments for additional siblings.** I understand that if I schedule an appointment with one child but no for my other(s) child, the practice might not be able to accommodate an encounter with a provider at the same time for my additional child. I understand that I need to schedule appointments ahead of time for all children.

**Insurance & Demographic Information.** Please allow time to update your records with practice prior to each encounter. I understand that it is my responsibility to update any demographic or insurance information and any consequence arising while billing my insurance. I understand that I need to have my insurance information with insurance card and active policy at each appointment. It is my responsibility to provide SuperKids Pediatrics and my insurance company with any and all information needed to process my claim for services in a timely manner.

 **Billing.** I understand that it is my responsibility to understand my Insurance coverage and limitations. I understand that SuperKids Pediatrics will collect all patient responsibility (copay) at the time of service and that payment in full and expected coinsurance payment responsibility are determined by the anticipated billing medical code(s), details of my insurance policy coverage and my agreement with my insurance. I understand that if my account is not paid in full within 90 days of a statement date, a 25% collection agency processing fee will be added to the outstanding balance and it will be turned to collection for further processing. I understand that no additional services will be provided for delinquent accounts until they are brought current. I understand that I am ultimately responsible for all professional fees incurred for services performed by the attending physician.

 **No electronics, food or smoking.**  I understand that the use of cell phone, recording devices, radios, electronic devices, headphones or ear plugs is not permitted in the examination rooms.  I further understand that no food, drinking, smoking (cigarette or vaping) is allowed in the office.

 **After-hours Call Service.** Please limit after-hour calls to urgent issues only.  For emergencies call 911. I understand that for refills, appointment requests, and other no urgent matters, I may leave a message or call the office during regular hours so that they can be appropriately managed by the appropriate care team. I UNDERSTAND THAT AN AFTER HOUR FEE OF $35.00 MAY BE ACCESSED FOR THE CONVINIENCE OF THE AFTER HOURS SERVICE.

 **Well Child Care (WCC) requirement.** I understand that SuperKids Pediatrics require full commitment with all recommended WCC visits. These visits include encounters at 1,2,4,6,9,12,15,18 and 24 months of life. One yearly visit thereafter. WCC visits are a condition for primary care provider-patient relationship with SuperKids Pediatric office. I further acknowledge that it is standard procedure for physicians to submit claims for “illness” related evaluations addressed during a scheduled well child examination visit.

 **Vaccine Policy Statement.** SuperKids Pediatrics recommends and firmly believes in the effectiveness of vaccines to prevent serious illness and to save lives, and in their safety.  I understand that SuperKids Pediatrics is not accepting new families who choose not to vaccinate their child.  In an effort to increase immunity within SuperKids Pediatircs patients and community, SuperKids Pediatrics will continue helping families who are delaying or choosing an “alternate” vaccine schedule.  However, I understand that SuperKids Pediatrics require a limit of 24 months of life for vaccine compliance based on the AAP vaccine schedule recommendations at 24 months.  I further understand the consequences if my child does not receive the vaccine(s). I understand that SuperKids Pediatrics could require further compliance for overseas travelers and/or with additional high-risk conditions.

I understand that my provider at SuperKids Pediatrics will spend time with me in discussing available science behind each intervention, concerns, myth busting, and how vaccines relate to diseases and preventive care.  I am aware that my insurance company may not reimburse me for vaccination or administration fees not completed while the appropriate well child encounter. In addition, I may be charge a copay or co-insurance for returning for an office visit to receive vaccines.

**ASSIGNMENT OF BENEFITS**:

SuperKids Pediatrics requires insured patients to complete assignment of benefit authorizing insurance to remit payment to physician’s office. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plan or health sharing plan to: SuperKids Pediatrics, SK Pediatrics PLLC, and/or any of its providers and subsidiaries. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

I have read and agree to all the provisions of the above Office Policies and statements.

Name of Guarantor or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_