



Pediatric Associates of Whidbey Island

275 SE Cabot Dr., Suite B102
Oak Harbor, WA 98277

1690 Layton Rd.
Freeland, WA 98249

Office Policy Including Missed Appointments & Financial

We would like to thank you for choosing *Pediatric Associates of Whidbey Island* (PAWI) as your child's doctors. We would like to keep you informed of our current office and financial policies. We require initials and a signature to document that you have read and understand these policies.

Initial **Well Check-ups (Well Child) visits are *REQUIRED***

At PAWI, we feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative care at the following ages:

- | | | | |
|--------------------|-------------------|--------------------|--|
| ❖ 3-5 days of life | ❖ 4 months of age | ❖ 12 months of age | ❖ 24 months of age |
| ❖ 1 month of age | ❖ 6 months of age | ❖ 15 months of age | ❖ 30 months of age |
| ❖ 2 months of age | ❖ 9 months of age | ❖ 18 months of age | ❖ 3-21 years of age
on a yearly basis |

Initial **Well visits & other concerns:**

Most insurance companies have advised us that, *for your convenience*, they allow for a well check-up and other concerns to be done at the same visit. This may result in additional charges in which co-pays and deductibles may apply. The following are examples:

1. An illness or injury is treated during a Well Child Visit
2. A pre-existing condition is addressed and managed during a Well Child Visit
3. A well visit is added-on to a sick visit because we have the time, and thus saving you the need to return.

Initial **Mutual Respect of Time (Missed Appointments):**

We pride ourselves on punctuality at PAWI. Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Call the office a minimum of 2 hours in advance if you are unable to make an appointment.
2. Arrive 15 minutes prior to your scheduled appointment time. This allows time to complete any paperwork that the provider needs for the visit.
3. Please let us know all the concerns for your child when making the appointment. This allows us to schedule the appointment appropriately and prevents us from running out of time and having to schedule another appointment to address other concerns.

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for your child. An appointment is considered missed when you either do not show up for that appointment or come in late. Late is not being here at the time of the scheduled appointment. At that time, you may be requested to reschedule or wait depending on multiple factors. We have implemented the following non-canceled Missed Appointments Policy. Your account will be subject to the following:

- First missed appointment: A courtesy call to alert you of your missed appointment.
- Second missed appointment: A reminder letter regarding non-canceled missed appointments. **We reserve the right to charge a \$20 fee for each non-canceled appointment after a second**

appointment has been missed. You will be responsible to pay this fee, as it is not billable to insurance companies. Like any other balance, scheduling future appointments may be affected if fees are left unpaid.

- Third missed appointment: You will no longer be able to schedule early morning or early afternoon appointments for well child or rechecks (only sick will be scheduled).
- New Patient: a non-canceled missed appointment will NOT be rescheduled.

More than 3 missed appointments, last minute cancellations, and/or late arrivals in a 24 month period are considered excessive and may result in discharge from our practice.

Initial **Payment:**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments, deductibles and non-covered services for participating insurance companies, regardless of who brings the child in for the appointment. We accept cash, personal checks (in-state only), and all major credit cards. Proper identification is required.

- There is a \$25 service charge for returned checks.
- Patients who do not pay the co-pay at the time of service may incur a billing fee of \$10.
- Patients who have an outstanding balance of 30 days may incur a rebilling fee of \$10 per statement for administrative costs.
- Patients with an account sent to collections, must satisfy account balance prior to making any additional appointments.
- Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except were prohibited by law or prior contractual agreement.

Self-pay accounts: \$100.00 time of service payment is required and the balance will be billed to the parent / guardian on file.

We realize that people have financial difficulty. Therefore, please stay in close communication with our billing department. Financial considerations should not prevent children from receiving the care they need at the time they need it. We require our office registration form be updated every other year, **or anytime there is a change in your contact information**, to ensure that we have the correct information for you. Incomplete or incorrect information can result in non-payment from your insurance.

Initial **Insurance:**

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card **at each visit**. If there is a change in your insurance coverage, please notify our office as soon as possible.

Initial **Primary Care Provider:**

Washington State (Apple Health), including Amerigroup, CHPW, Coordinated Care, and Molina require that *Pediatric Associates of Whidbey Island* is listed as the primary care provider. It is your responsibility to ensure that your child's PCP is listed correctly. You will be notified several days before if the PCP is not correct. If the PCP is not changed the day before the appointment the appointment **will be canceled**.

If your insurance plan requires, you must name *Pediatric Associates of Whidbey Island* as your primary care physician. If a *Pediatric Associates of Whidbey Island* physician is not named on your insurance as your primary care physician, your appointment may need to be rescheduled. It is the parent's responsibility to contact your plan to update this information when needed.

____ *Initial* **Unpaid Accounts**

If your account has been turned over to a collection agency, you will be responsible for all costs and expenses of collection including, but not limited to reasonable attorneys' fees.

____ *Initial* **FOR APPLE HEALTH CLIENTS:** Washington Medicaid Insurance Policy

If your child has Washington Medicaid (Apple Health/CHPW/Coordinated Care/Amerigroup /Molina) and is also covered under a private health insurance plan, we are required by law to file claims with the private insurance policy first. Washington State plans are *always* considered a secondary insurance.

It is the responsibility of the parent to keep the State of Washington updated with private insurance information. If the State of Washington is not informed that your child also has private insurance, they have the right to retract payment from a previously paid claim. If this occurs, then the entire balance will be the **responsibility of the parent/guardian on file.**

By signing this notice, you acknowledge receipt and understanding of this Office Policy as outlined above and understand the consequences. You also understand that you are ultimately responsible for the charges incurred by your child(ren) as their legal parent or guardian.

____ *Initial* **Newborns**

** If your Health Insurance is Provider One (Apple Health) you must contact Provider One **FIRST** to add your child. You can contact the Island County WA State Health Care Authority representative Heidi Beck at 360-725-9512 for assistance.

Please list full names of your child(ren)

_____	_____
_____	_____
_____	_____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date Signed _____