MEADOW
PEDIATRICS

NO SHOW/LATE ARRIVAL POLICY

Late Arrival Policy:

- **Scheduled Well Child or Physical:** If you arrive more than 15 minutes late, the appointment will be rescheduled for another day.
- **Scheduled Sick or Office Visit:** If you arrive more than 15 minutes late, you will be worked in and seen as soon as the schedule allows.

No-Show Policy:

Patients who fail to present for a scheduled appointment without contacting the office to cancel the appointment within 24 hours will be considered a "no-show". Patients who consistently fail to present for scheduled appointments will be considered a "chronic no-show" (3 no-shows in a 12-month period).

Purpose:

Meadow Pediatrics strives to provide quality health care services at all times by scheduling patients in a timely manner, to maximize the time the physician spends with you and minimize your wait-time. Also, a missed appointment is an opportunity for another family to be scheduled.

Procedure:

All insured and non-insured patients will be charged a $50 "no-show" fee and may be dismissed from the practice after multiple no-shows.

I, _____, have read and understand the above stated policy.

Signature: _____Date: _____

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CONSENTS

Insurance:

In order to comply with your insurance **all copayments, co-insurance, deductible and/or non-covered services must be paid at the time service is rendered.** Please remember that insurance is considered only a method of reimbursement to the physician for services you have received – making you ultimately responsible. If there are any questions regarding the payment or insurance filing policies, please see one of the office staff at this time to make any necessary arrangements. Regardless of custody arrangements or divorce decrees, the person bringing a dependent in for services is responsible for all copayments, etc., and is expected to pay at the time service is rendered.

I acknowledge that I am responsible and liable for all charges assessed for professional services rendered regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Meadow Pediatrics. I understand that I am responsible for my deductible, coinsurance and any non-covered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize my insurance company to release any medical information necessary to process pending and/or unpaid claims, and hereby assign payment of all medical benefits to Meadow Pediatrics.

Consent to Treat:

I hereby consent to the treatment for the above listed child as the parent or legal guardian of the patient. I further understand that prior to services being rendered, I must submit in writing my approval for anyone else to bring this child for services such as a grandparent and/or other relatives.

Health Insurance Portability and Accountability Act (HIPAA):

I consent to the use or disclosure of my protected health information (PHI) by Meadow Pediatrics, PLLC (the Company) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Company's Notice of Privacy Practices (the Notice) prior to signing this document. I have received a copy of the Company's Notice. The Notice describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Company. The Notice for the Company is also provided on the Company's website at www.meadowpediatrics.com. This Notice also describes my rights and the Company's duties with respect to my PHI.

The Company reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised notice of privacy practices by accessing the Company's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Parent's/Guardian's Signature and Date