# Farrington Pediatrics

# Office Policy Acknowledgment Form

Our goal is to provide and maintain a good physician-patient relationship. Understanding our office policy allows for clear communication and a smooth experience. Please read each section carefully, initial where indicated, and sign at the bottom. If you have any questions, please ask a member of our staff.

## Appointments

1. We value your time and do not double-book appointments. If you cannot keep an appointment, please provide at least 24-hour notice. A $20 fee applies for missed appointments.
2. Emergencies take priority over scheduled visits. We appreciate your patience.
3. Before scheduling an annual physical, confirm with your insurance whether it is covered as a well-child visit.
   **Initial: _____**

## Insurance Plans

1. It is your responsibility to provide accurate and updated insurance information. Incorrect information may result in financial responsibility for the visit.
2. If we are your designated Primary Care Physician, ensure our name or phone number appears on your insurance card. Else, you may be financially responsible for your visit.
3. Understand your insurance benefits regarding covered services and participating laboratories.
   - Not all plans cover annual well-child visits, sports physicals, or hearing/vision screenings. If not covered, you are responsible for payment.
   - Some plans limit the number of well-child visits for children under 2 years old. If exceeded, you will be responsible for payment.
4. It is your responsibility to know if a referral, authorization, or preauthorization is required.
   **Initial: _____**

## Referrals

1. Non-emergent referrals require 3 to 5 business days' notice.
2. Ensure your chosen specialist participates in your insurance plan.
3. All referrals must be approved before issuance.
   **Initial: _____**

## Financial Responsibility

1. You are responsible for all co-payments, deductibles, and co-insurances.
2. Co-payments are due at the time of service.
3. Self-pay patients must pay in full at the time of the visit.
4. If we do not participate in your insurance plan, full payment is required at the time of service. An invoice will be provided for you to seek reimbursement.
5. Patient balances are due within 10 business days of receiving your bill. Outstanding balances over 90 days will be sent to a collection agency.
6. Prior balances must be paid before scheduled appointments.
7. Payment methods accepted: Cash, Checks, Credit Cards (2.5% surcharge), HSA/FSA (no surcharge), Zelle to farringtonpediatrics@gmail.com.
8. Additional school, camp, or sports forms require a $10 fee per form, payable at drop-off. A 3-day turnaround time applies.
   **Initial: _____**

## Transfer of Records

1. If transferring to another physician, we provide a copy of immunization records and the last visit record free of charge with 48 hours' notice.
2. A complete record copy is available for $1 per page.
3. We provide records only for visits at Farrington Pediatrics. For prior records, request them from previous providers.
   **Initial: _____**

## Prescription Refills

1. Monthly medication refills require 48 hours' notice during regular business hours. Plan accordingly.
   **Initial: _____**

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## Acknowledgment and Agreement

I have read, understand, and agree to the office policy. I accept responsibility for any payments due as outlined above.

**Patient Name(s):** _____

**Responsible Party Name:** _____ **Relationship:** _____

**Responsible Party Signature:** _____ **Date:** _____

Upon completion, a copy of this form will be provided for your records.