Office Policies

For the Pediatric Practice of Drs. Lovenheim, Yoo, Mathew, and Thomas

Our goal is to provide and maintain good physician-patient relationships. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goals to provide the most comprehensive healthcare for your children. Please read each section carefully and sign at the bottom. Upon completion, return the signed "Authorization" page to the receptionist. The copy of the policy is yours to keep. If you have any questions, please do not hesitate to ask a member of our staff.

Appointments

- We value the time we have set aside to see and treat your child. We do not intentionally double book appointments so if you cannot keep that appointment, with ample notice we can give that time to someone else. If you are not able to keep an appointment, we require 24 hours' notice. If you make an appointment for a sick visit, and your child feels better prior to the appointment, please call and let us know you will not be coming in so that time can be given to other sick children. If you fail to let us know, a $30 fee will be added to your account. Families who have multiple "No Show" appointments may be discharged from the practice.
- If you are late for your appointment (10 minutes or more), we will do our best to accommodate you however, on certain days it may be necessary to reschedule your appointment.
- We strive to minimize any wait time however emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
- We require that all our patients have yearly well-child check-ups. It is wise to schedule them a year in advance (at the current check-up) so that you will be sure to get the date and times that work best for you. Be aware that your insurance plan may require a full 12-month time span between routine check-ups. Know the date of your child's last physical when scheduling new appointments.
- At all visits we will be asking you (or the person accompanying the patient) to present the insurance card as well as a photo identification. Please let us know the names and relationship of any other adult who might be bringing your child for their visits.

Insurance Plans

- We participate in most insurance plans however each plan varies as to the benefits that are covered. It is your responsibility to understand your benefit plan regarding covered services. If any service we provide is not covered under your plan, you will be responsible for payment.
- Physicians are only allowed a short window of time to submit claims for your visits. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit. We would be happy to resubmit the charges to the correct insurance company and would then reimburse you once they have paid us.
- If you have selected us as your primary care physicians, please make sure that you have notified your insurance carrier and that our name is listed on your insurance cards. If claims are denied because we are not listed as your PCP, you may be responsible for the cost of the visit.

Referrals

Some insurance companies require a referral before you can see a specialist. In most cases we cannot provide a referral without first seeing the patient. If you require a referral for an existing condition that we are not aware of, we do require 72 business hours' notice to process the referral.

Medical Records

- If you are transferring to another physician, we require 2 weeks' notice to process your request and copy your records. There is a $20.00 per chart charge which is payable in advance of processing your request. We do require written request.

Forms

A $10 form fee will be charged for forms that parents/patients request to be filled out by a physician or nurse. FMLA Forms will be charged $25 to be filled out. Payment for the forms must be made before the forms are processed by the office. Forms will only be accepted for completion if the sections that need to be filled out by the patient or parent are already completed.

Forms can take as long as 2 weeks to complete particularly in the spring and summer. You will be called when the forms are completed, and the forms will be waiting at the front desk.

"Rush" jobs will be completed within 48 hours for an additional $10. If you would like your forms mailed to your home or another address, you must include a self-addressed stamped envelope. Only accounts that are in good standing and patients with current physicals (within 12 months of the time the form is being completed) will be processed.

Financial Responsibility: Please be aware that before we can offer you an appointment time for any visit, prior balances must be paid prior to the visit.

- According to the contract you entered with your insurance plan, you are responsible for all co-payments, deductibles and coinsurances at the time of your visit. Self-pay patients are expected to pay for services in full at the time of the visit. If we do not participate in your insurance plan, payment in full is expected at the time of your visit. We will supply you with an invoice that you can submit to your insurance company for reimbursement.
- Copayments are always due at the time of service as per your policy's requirement. We are not allowed to see your child if you do not pay your co-payment. A $25 service fee will be charged in addition to your copayment if the copayment is not paid by the end of that business day.
- The adult accompanying the patient to our office is responsible for payment of the applicable co-payment, deductible or coinsurance regardless of whether it is the parent or guardian. For instance, if another family member brings your child to the office, they should have with them a copy of your insurance card and applicable payment. In divorce or separation situations, we do not split the financial responsibility, nor do we bill 2 separate individuals. The adult accompanying the patient to our office is responsible for payment of the service.
- Patient balances are billed immediately upon receipt of your insurance plan's Explanation of Benefits (EOB). Your remittance is then due within 10 business days of your receipt of your bill. We will charge interest, as allowed by law, and after 90 days if you have not satisfied payment, or made other arrangements, your account will be sent to collection, and you will be responsible for any legal costs involved in collecting your past due account.
- **For your convenience we accept cash, checks, debit cards, and credit cards (Visa, MasterCard, and American Express). A $35 fee will be charged for any checks returned for insufficient funds and from that point forward we will accept only cash transactions.**

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Authorization of Treatment and Assignment of Benefits

I, _____ authorize Drs. Lovenheim, Yoo, and Mathew to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school and camp forms, etc.

I authorize payment directly to Drs. Lovenheim, Yoo, and Mathew for all medical or surgical benefits otherwise payable to me under the terms of my insurance.

I also affirm that I will reimburse Drs. Lovenheim, Yoo, and Mathew for any payments my insurance company may have sent to me directly.

I understand that I am financially responsible for all co-payments, deductibles, co-insurance and any charges not covered under my insurance benefits.

I also understand that I am responsible for advising Drs. Lovenheim, Yoo, and Mathew of all changes to my insurance coverage and will present Drs. Lovenheim, Yoo, and Mathew with proper member identification and photo identification at the time of each visit.

I have read and understand the office policies presented to me on the accompanying pages and agree to comply and accept responsibility for any payment that becomes due as outlined previously. I understand that it is my responsibility to inform other caregivers, or others, who might bring my child/children into the office of the above policies.

Patient Names: _____ _____

_____ _____

Responsible Party: _____ Relationship to patient: _____

Please print

_____ Date: _____

Signature