WOODBRIDGE PEDIATRICS, LTD. Practice Policy

We are committed to providing you with the best possible care and would like you to understand our policies.

For patients with participating insurance plans, all co-payments are due at time of service; a $10 fee will be assessed for co-payments that are not paid in full at time of service. **Although your insurance may not charge a copay for Well Care, please be aware that your insurance may charge you a copay for any additional problems addressed by the Physician during Preventative Well Care.**

Payment for your office visit is required at the time of service for the following:

•Patients without insurance •Patients with private insurance, who are not covered by one of our participating plans

•Patients who do not provide us with complete insurance information.

If you need to use a specified laboratory or x-ray facility, it is your responsibility to inform our office before the service is rendered. Any laboratory order that you have not completed within 30 days will be deleted from our system.

If you are being seen for a condition/problem that is not a covered benefit of your insurance policy, it is your responsibility to pay at time of service.

Payment is due at the time services are rendered. We accept cash, checks, and credit (Mastercard, VISA, and Discover). Returned checks will be charged a $50 fee. There is a $10 form fee applied for any forms that require a doctor's signature. A $30 fee will be charged for each copy of a requested record. Please allow up to 30 days for a record to be copied once a SIGNED REQUEST is received.

All accounts that have unpaid balances after 90 days will be turned over to a collection agency. You will be responsible for any fees charged by the collection agency and all costs and expenses including reasonable attorneys' fees, we incur in such collection efforts.

Woodbridge Pediatrics reserves the right to change their fees at any time.

Release of Medical Records and Immunization History

I authorize Woodbridge Pediatrics to release and/or send medical information/records with regard to my child's health condition to other consultants and/or referring physicians, licensed healthcare facilities, health departments, and /or any education facilities as appropriate. Woodbridge Pediatrics will share immunization information with other physicians, hospitals, and health departments for purposes of ensuring that he/she receives age appropriate immunizations. Furthermore, I understand that the information may be released by forwarding a photocopy through the U.S. postal service or by confidential facsimile.

Deemed Consent - Virginia

I understand that Virginia law (VA Code Ann. § 32.1-45.1) provides that if my physician or any person employed by my physician is exposed to my child's body fluids in a way that might possibly transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to allow testing for HIV and/or Hepatitis B or C infection. The results of this testing must be made available to the person who has been exposed to those body fluids. If the person whose blood specimen is sought for testing refuses to provide such specimen, any person potentially exposed to the HIV or hepatitis B or C viruses, or the employer of such person, may petition the general district court for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with the law.

It is your responsibility to know and understand your own insurance policy. If you have any questions about our services, fees, or other aspects of your care, please do not hesitate to contact us.

I understand by signing I have **read and agree** to the above paragraphs. I understand that I am 18 years of age or older and financially responsible for all charges, co-payments and any charges not paid by my insurance.

Parent/Guardian's (Person responsible for payment)

Signature:_____Date:_____

PLEASE DO NOT FORFGET TO READ & SIGN THE OTHER SIDE OF THIS FORM: THANK YOU

Turn Over

Turn Over

WOODBRIDGE PEDIATRICS, LTD

POLICY FOR MISSED APPOINTMENTS

I, _____, a parent or legal guardian of:
List Child(ren) Name and Date of Birth:

_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #
_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #
_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #
_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #

All appointments need to be cancelled with at least 24 hours notice. If you do not cancel your appointment in the appropriate amount of time the following fees will be applied:

- $75 missed appointment fee for Well Care/Physicals
- $30 missed Physician appointments
- $10 missed Nurse appointments

I understand that if I have multiple children scheduled, each child will be charged a missed appointment fee. It is also our policy to dismiss patients who do not show up for any two scheduled appointments. Two missed appointments in a family will result in dismissal from the practice.

If you are more than 15 minutes late for your appointment we reserve the right to cancel the appointment and fees will apply.

CONSENT AGREEMENT FOR PRIVACY NOTICE

I, _____,have received a written copy of **Woodbridge Pediatrics Privacy Notice**. I also understand my rights regarding my individually identifiable health information (IIHI) as presented in the Privacy Notice and I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment, or other healthcare operations (TPO) only. Other uses of my IIHI will require an authorization form from me for the specific intention of the disclosure.

I also authorize Woodbridge Pediatrics to use the name of the patient and family members as needed for identification purposes in public areas of the office.

Patient _____

Parent Representative _____

Signature _____ Date _____

I understand by signing I have **read and agree** to the above paragraphs. I understand that I am 18 years of age or older and financially responsible for all charges, co-payments and any charges not paid by my insurance.

Signature:_____Date:_____