**OFFICE POLICIES**

**(Revised January 2024)**

Welcome to SGH Pediatrics. We are pleased you have chosen us to be your child’s healthcare provider. We strive to make your experience with our office a pleasant one. This purpose of this document is to establish and maintain a good physician-patient relationship. Keeping our patients informed of our office policies allows for the responsibilities to be clearly defined. It is our goal to provide clear communication so we can achieve our mutual goals. ***Please read each section carefully***. If you have any questions, do not hesitate to ask a member of our staff.

**Office hours:**

Monday – Friday 8:00AM-Noon and 1:00PM to 4:45PM

Effective March 10th 2018 we will no longer be offering Saturday sick clinics. Please see urgent care recommendations.

**After Hours:**

We are always available to assist you during our regular hours. For questions that arise when our office is closed, we are pleased to provide you with access to our Children’s nurse triage phone line. A physician is always on call to provide backup for an issues that cannot be handled by our nurses. The after-hours number is toll-free, (855) 456-6976. You may also call our office and follow the prompts. There is a $25 (per phone call) charge to speak with the physician after-hours. This charge is not covered by your insurance.

**Appointments:**

1. Our receptionists are available to schedule appointments beginning at 8:00AM Monday- Friday. In an effort to minimize your hold time, we encourage you to call after 10AM to schedule routine appointments.
2. Patients are seen, ***by appointment only***. We are not a walk-in clinic and strongly discourage patients from walking into our office to obtain an appointment. As you will be offered the next available appointment.
3. **Well-Child exams-** are essential in ensuring the proper health and development of your child. We recommend annual well checks be scheduled 2-3 months in advance, as these appointments do book up quickly. We do not automatically schedule well appointments for patients. It is the responsibility of the parent to schedule their child’s well-child exams. Your child’s well exam will act as their sports physical. Please bring your UIL or sports form with you. We will be happy to complete it for you at the time of their exam.
4. **Same day sick visits** are scheduled on a first-come, first-serve basis. We will attempt to accommodate all same day sick visits requested before noon; however, there may be times we are not able to get you in, as these appointments are limited.
5. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
6. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, it may be necessary to reschedule your appointment.
7. **Appointment No Show Policy**: Failure to cancel your appointment within 24 hours’ notice will result in a $25.00 charge. This charge must be paid prior to scheduling your next appointment.

**Insurance Plans:**

1. It is your responsibility to keep the front office staff informed of your correct insurance information. If the insurance company you designate is incorrect, or if medical services delivered fall outside of your coverage parameters, you will be responsible for payment. We are happy to provide you with documentation of the visit charges so that you can submit it to the correct plan for reimbursement.
2. You are responsible for paying your co-pay, meeting any outstanding deductible or coinsurance before seeing the doctor, based on anticipated medical services being provided.
3. If your plan requires a designated primary care physician, it is your responsibility to make sure our name appears on the front of your card. If you insurance company has not been informed you, you may be financially responsible for your current visit.
4. We make every attempt to let you know of charges not covered by your insurance plan prior to your visit. However, there will be times that we will be unable to do so, since each plan is different. We are not always able to anticipate what your doctor will determine to be medically appropriate at the time of each visit. Your provider will recommend care based on what she deems medically appropriate, and not based on what your insurance will cover. It is your responsibility to understand your insurance plan benefits. For questions or concerns pertaining to what your insurance will or won’t cover please call the number on the back of your insurance card.

**Referral:**

1. Should you require a referral to a specialist, please allow 5 business days for all non-emergent referrals.
2. It is your responsibility to know if Pre-authorization is required to see specialist prior to a visit or procedure.
3. It is your responsibility to know if the specialist participates with your insurance plan.
4. Remember, we must approve referrals before they are issued.

**Financial Responsibility:**

1. You are financially responsible for any and all copayments, deductibles and coinsurance, as well as for all non-covered items and rendered services at the time of your visit. If you refuse to pay your required amount at the time of service, you may be denied care for that date of service.
	1. Copay – A dollar amount contracted between you and your insurance carrier, due at the time of service.
	2. Co-Insurance – A percentage of the insurance benefits that you are responsible for.
	3. Deductible- a yearly dollar amount that you are responsible for based on the type of coverage you have selected with your insurance company.
2. Self-pay patients are expected to pay for service in **FULL** at the time of the visit.
3. If we do not participate in your insurance plan, payment in full is expected from you at the time of the visit. We will provide you with an invoice for you to submit to your insurance plan for reimbursement.
4. If you participate in a high deductible plan a copy of your HSA, Flex, or credit card is required to be on file. Your card will not be charged until after your insurance has processed your claim. Any patient responsibility balance will be charged to the card on file.
5. We accept cash, check, visa, master card, Discover, Amex.
6. A $60 fee will be charged for any checks returned for insufficient funds.
7. For scheduled appointments, prior balances must be paid before the visit.

**Forms:**

1. Various forms and letters are often lengthy and may take extra time to be filled out. Any forms, letters, school, camp, or sports form not processed with a visit are subject to a $20-per-form fee. Payment is due when the forms are dropped off. Turnaround time is 3 business days. FMLA paperwork for your child does require 5 business days and will incur a $35 fee.
2. We will gladly fill out forms long as your child has had a Well Child exam within the last 12 months. If your child is not up to date with his/her Well Child Exam, they will need to be seen for said exam prior to any forms being filled out or signed off on.

**Records requests:**

1. Requests for medical records must be made in writing by completing our Authorization to Release medical records, and have the signature of a parent or guardian. Medical records request for personal use will incur a charge of $25 for the first 20 pages and $0.50 per page thereafter.
2. If you want your child’s records transferred to another healthcare provider, please complete our Authorization to Release Medical Records. When you transfer to another physician, as a courtesy to you, we will provide a copy of your child’s records to one physician’s office, free of charge. Please allow 14 business days for processing.
3. We will provide record of your child for visits (including consultations from specialists) rendered here at SGH Pediatrics only. For any other records, you must request them directly from your previous physician’s office.

**ADD/ADHD**

1. Requirements to obtain a prescription refill are as follows:
	1. Your child must be seen twice per year, once for a well check, and once for ADD/ADHD follow-up. If your child’s visits are not up to date, **we will not issue a prescription.**
2. ADD/ADHD refill request will require 3 business days to process, please plan accordingly.

**Prescriptions**

1. For monthly medication refills, we require 3 business days’ notice, during regular business hours. Please plan accordingly.
2. By signing this form, I authorize SGH Pediatrics to obtain my child’s medication history electronically as part of an electronic health record.

**NOTICE CONCERNING COMPLAINTS**

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018 Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353 For more information please visit our website at [www.tmb.state.tx.us](http://www.tmb.state.tx.us)

**AVISO SOBRE LAS QUEJAS**

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas: Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018 Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353 Para obtener más información, visite nuestro sitio web en [www.tmb.state.tx.us](http://www.tmb.state.tx.us)

**Patient Agreement**

I acknowledge that I have read and understand the policies and procedures of SGH Pediatrics as outlined in this document. I agree to adhere to the specific policies of SGH Pediatrics. I am aware that if I do not comply with the above stated guidelines, SGH Pediatrics reserves the right to terminate care with the office.

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name/DOB:

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