

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Cornerstone Patient Packet Form Checklist

Complete and Return the following forms to our office to schedule an appointment.

- Cornerstone Patient Packet Checklist (this page)
- Signed "Cornerstone Fit Checklist"
- Patient Registration
- Medical Records Release

\*This form is to be completed and sent to your current pediatrician (if applicable) so that we may get your child's vaccine records and past medical records. PLEASE complete the name/address/phone/fax for your past provider (if applicable)

- Authorization for Medical Treatment
- Initial Health History Questionnaire
- No-Show/Late Arrival Policy Signed
- Copy of Insurance Card (front and back please)

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For office only:

- Packet completed
- Copy of Insurance
- Registered/eligible
- MRR faxed
- MRR/vaccines rec'd
- Packet in Athena
- Vac/MR in Athena
- Scheduled

Name of Patient: \_\_\_\_\_

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## Choosing Cornerstone Pediatrics

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### Are We a Good Fit for You ?

It is crucial when choosing a pediatric practice for your children that you have given serious consideration to the fit between the practice philosophies and your own. **Excellent care happens when the physician and office staff are aligned with your family priorities and philosophies regarding care. We strive to share decision-making based on mutual respect.**

Please read the following over carefully to be sure Dianne McNeill, MD and Cornerstone Pediatrics is a good fit for you and your children. **We look forward to meeting you and forming a mutually rewarding relationship.**

### **Benefits of a Solo Practitioner**

In this practice, **every** appointment is made with Dr. Dianne allowing a **personal relationship to be built between the patient, the family, and the pediatrician**. As your child grows, they are followed by their same pediatrician who knows their history as well as their personality. Also, every phone message, portal message, referral, specialist note and test is reviewed by Dr. McNeill.

As a solo practitioner, Dr McNeill is dedicated to improving and maintaining your child's health through preventive and integrative pediatric care. **Dr. McNeill's mission for Cornerstone Pediatrics is to provide you with exceptional personalized quality care in a warm and friendly environment.**

### **Prenatal:**

*Prenatal visits* can be done by telemedicine from the comfort of your home! These meetings are a great way to get to know your potential pediatrician and to get comfortable with our office and ask questions. But if you would prefer to visit the office, we can schedule an in person prenatal visit as well! Prenatal visits are not required, and there is no charge for these visits.

Dr. McNeill does not see newborns in the hospital. Instead, the experienced newborn hospitalists will determine the care your baby will receive there. As soon as you know when you are being discharged from the hospital, please call our office to schedule the baby's first visit. We will arrange for the first visit within 2-3 days of discharge. Please be sure to let us know when you call if there are any concerning medical problems in the hospital, such as prematurity, jaundice or weight loss.

### **Vaccines**

Our vaccine policy follows the schedule outlined by the AAP (American Academy of Pediatrics) and the CDC (Centers for Disease Control and Prevention). **We believe the single most important preventative medical intervention is vaccines.** We are happy at your child's well care visit to discuss vaccines, the science behind vaccines, your questions, concerns and our recommendations. **Our goal is to work *with* you, *not* against you.**

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We recognize that the choice to vaccinate may be an emotional choice for some parents, but as we feel so strongly about this issue- **we do not accept patients whose parents refuse all vaccines.** As a result, if your immunization philosophy differs from our view, we would ask that you choose another medical office for your child that aligns with your preferences and shares your medical philosophy.

### **Scheduling Appointments**

Please call our office number **757-410-9600** to schedule appointments. We do our best to accommodate **same day sick appointments** for our patients, but recommend that consults, chronic medical condition appointments be made in advance to best accommodate your child and Dr. McNeill's schedule.

**Sometimes an appointment may not be needed.** For questions and concerns you may have about your child's health, development and/or behavior, you can call our office during business hours and our nurse or our experienced medical assistants can triage your concerns. **Well child visits may be scheduled up to 3-6 months in advance. Please call during routine office hours to schedule these appointments or send us a message on the patient portal.**

### **Office Hours**

We make every effort to meet the needs of our patients, we schedule both routine well visits and sick visit appointments during traditional business hours on Monday, Tuesday and Thursday. We highly recommend you call ahead to schedule an appointment. **We see same day sick visits on Mondays, Tuesdays, Thursdays and Friday mornings.**

**Please familiarize yourself with our office hours to see if they work for your family.**

### **After hours**

If your child is a patient of Cornerstone and you have concerns about your child being sick outside of regular business hours, you can call the office phone number at 757-410-9600. This phone number will be answered by the answering service who will contact our Anytime Pediatrics on call service. There is always a doctor on call 24/7 and you should never feel your child's care is uncovered. Many insurance plans also offer a On-Call service as noted on your insurance card. If it is a non urgent question that can wait until the next business day, please wait for normal business hours or send a message to our patient portal.

### **Insurance**

**Please be sure we participate with your insurance plan.** With the myriad of insurance plans available to our families, it is **your responsibility** to know the limits and coverage of your particular health insurance policy. We will do our best to assist you with your insurance plan; however, if you have questions about your coverage, it is your responsibility to check with your specific insurance company.

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**We will ask you to bring your insurance card and ID at each visit, and please be prepared to pay any co-pays, deductibles and balances at the time of service.** Our office does not want you to be surprised by a bill, but we must always bill your health plan based on federal guidelines and the actual services provided. **IF AT TIME OF APPT, YOU ARE INELIGIBLE OR YOUR INSURANCE IS NOT CORRECT, WE HAVE THE RIGHT TO CANCEL YOUR APPOINTMENT AND RESCHEDULE WHEN YOUR INSURANCE HAS BEEN VERIFIED.** For annual physicals, many insurance companies will not cover 2 physicals within a one year period. Please contact YOUR insurance company to verify coverage for physicals if you have questions.

### **Billing and Fees**

**Insurance co-pays, deductibles and balances are expected to be paid at the time of service.** If you are unable to comply, you must work with our office prior to the visit to set up a payment plan.

### **Credit Card on File**

Cornerstone Pediatrics is committed to making our billing process as simple and easy as possible. **For this reason, we require that ALL patients provide a credit card on file with our office.** We will scan your card with a card reader that will store your card number in a **secure** location in your electronic medical record. **For security reasons, only the last four digits will be visible to our staff.** Credit cards on file may be used to pay co-pays, coinsurance and when you are seen in our office, and will be used for any deductibles and/or account balances after your insurance processes your claim. You will receive an email notifying you prior to the CARD on file being charged.

### **Timeliness & Missed Appointments**

We gladly reserve appointment times for you and appreciate that you have chosen Dr. Dianne and Cornerstone Pediatrics for your care. As a courtesy, we will remind you of your appointment by calling you prior to your scheduled date and time. If we cannot speak directly to you, we will leave a message. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment.

We respect our patients' valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. **We reserve the right to charge a no-show fee of \$50 for regular appointments canceled or broken without advance notice of 24 hours. After three (3) "no shows" we reserve the right to discharge your family from our practice.**

We understand sometimes things happen beyond your control that may cause you to be late. However, we reserve the right to ask you to reschedule if you arrive late for your appointment. We look forward to meeting you and your child and providing the quality, comprehensive medical care.

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **Forms**

The following forms to be filled out by Dr. McNeill require the child to have had a well child check up in the last twelve months:

- School/Daycare Physical Forms
- Sports Physical Forms
- Administration of Medication Forms
- WIC Forms

Often form completion may require an Office Visit, these include completion of FMLA Forms, DMAS-7, EFMP, etc.

In order to provide excellent and efficient care to our families, we ask that you please bring any physical, sports, medication forms, etc that you need to be completed to your visit with YOUR PORTION already completed. We will do our very best to complete forms that are brought in **at time of visit** so that you leave with everything you need. If you bring in the form at a later time, we will gladly complete it for you at no charge, but we ask that you please allow us 3-5 business days to have the forms completed, reviewed and signed by Dr. McNeill.

For URGENT form completion (needed within 24 hour turnaround time), there is a \$10 charge.

## **Ongoing Consults for Chronic Conditions**

Because Dr. McNeill is a solo practitioner, we try to be respectful of set appointment times. Wellness visits are a time to discuss growth, development and simple concerns you and your child may have. Dr. McNeill won't be able to address chronic issues that require medications and follow-up at your child's wellness visit. Dr. McNeill wants to make sure all of your child's needs are addressed and that is why chronic issues are best addressed in a separate appointment. If your child has a chronic condition that requires ongoing medication, additional appointments are necessary to manage care in accordance with the American Academy of Pediatrics standards of practice.

Regular interval monitoring for treatment tolerability and response is recommended for:

- Asthma/Allergies/Eczema (every 3 months)
- Chronic Constipation
- Acne, treated with prescription medication (every 3 months)
- ADHD: see specific protocol (every 3 months)
- For other prescribed medication management

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## **Cornerstone Fit Checklist**

**If it appears that we ARE a good fit (hooray!), please initial to assure us that you have reviewed the following:**

\_\_\_\_\_ Cornerstone Pediatrics does not accept patients whose parents *refuse all* vaccines.

\_\_\_\_\_ Cornerstone is NOT responsible to know the limits and coverage of your particular health insurance policy. It is *your* responsibility to check with your specific insurance company. IF YOUR INSURANCE IS NOT VALID OR ELIGIBLE AT THE TIME OF YOUR APPOINTMENT, WE RESERVE THE RIGHT TO RESCHEDULE.

\_\_\_\_\_ Cornerstone reserves the right to charge a no-show fee of \$50 for regular appointments canceled or broken without advance notice of 24 hours. After three (3) “no shows” we reserve the right to discharge your family from our practice.

\_\_\_\_\_ Insurance co-pays are expected to be *paid in full at the time of service*. If you are unable to comply, you must work with our office prior to the visit to set up a payment plan.

\_\_\_\_\_ We require that all patients provide a credit card on file (securely) with our office.

\_\_\_\_\_ If your child has a chronic condition that requires ongoing medication, additional appointments, separate from the wellness appointment, will be necessary to manage care in accordance with the American Academy of Pediatrics standards of practice

\_\_\_\_\_ The following forms to be filled out by Dr. McNeill require the child to have had a well child check up in the last twelve months: School/Daycare Physical Forms, Sports Physical Forms, Administration of Medication Forms, WIC Forms. The following require an office visit to properly complete the paperwork for FMLA, DMAS-7, EFMP, etc.

\_\_\_\_\_ Forms to be filled out should accompany your child at their wellness visit if possible. If you need a form completed at a later time, we will gladly complete it for you, free of charge, but we ask that you please allow us 3-5 business days to have the forms completed, reviewed and signed by Dr. McNeill.

\_\_\_\_\_ For urgent form completion (24 hr turnaround time), there will be a \$10 fee.

When was your child's last well-child visit? \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **Cornerstone Pediatrics Patient Registration**

Prospective Patient Legal Name:

Last \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ DOB \_\_\_\_\_

Legal Sex: \_\_\_\_\_ First Name Used/Nickname: \_\_\_\_\_

Home Address: \_\_\_\_\_ Best email: \_\_\_\_\_

\_\_\_\_\_ Alt email: \_\_\_\_\_

Parent/Guardian Contact

1. Phone: \_\_\_\_\_ Name: \_\_\_\_\_ Type: cell home work

2. Phone: \_\_\_\_\_ Name: \_\_\_\_\_ Type: cell home work

Address if different from patient: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt phone # \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt phone # \_\_\_\_\_

Guardian 1: Mom/Dad/Other: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

Employer phone: \_\_\_\_\_

Guardian 2:

Mom/Dad/Other: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

Employer phone: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Demographics:

First Language: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Marital status of parents: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Guarantor (name to whom statements are sent):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing address if different from patient: \_\_\_\_\_

INSURANCE INFORMATION:

Primary Insurance Name: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Relation: \_\_\_\_\_

Group # \_\_\_\_\_ ID/Cert # \_\_\_\_\_

Issued: \_\_\_\_\_

**Reminder: Please be sure we participate with your insurance plan. With the myriad of insurance plans available to our families, it is your responsibility to know the limits and coverage of your particular health insurance policy. We will do our best to assist you with your insurance plan; however, if you have questions about your coverage, it is your responsibility to check with your specific insurance company.**

**We must have a copy of insurance to schedule an appointment.**

**We will ask you to bring your insurance card and ID at each visit, and please be prepared to pay any co-pays at the time of service. Our office does not want you to be surprised by a bill, but we must always bill your health plan based on federal guidelines and the actual services provided.**



Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



**Patient Name/ DOB:**

Dianne McNeill, M.D., FAAP

**Authorization to Use or Disclose Protected Health Information  
Medical Records Release**

At my request, I authorize:

PRIOR Practice/Physician name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

To Disclose/Transfer the Following Information:

- All Records
- Immunization/Vaccine Records (  please fax to 410-9640 ASAP)
- Other (Specify) \_\_\_\_\_

To Disclose/Transfer records to:

Dianne McNeill, M.D., FAAP  
Cornerstone Pediatrics  
308 Cedar Lakes Drive, Suite 103  
Chesapeake, VA 23322  
Phone 757-410-9600  
Fax 757-410-9640

Purpose of Disclosure:

At the request of the patient/legal guardian

\*I understand that I may revoke this authorization at any time by notifying the office in writing. I understand that this authorization expires 1 year from the date signed.

\*I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws/regulations.

\*I understand that photocopy or facsimile of this authorization is as valid as the original.

\*I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individuals protected health information.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



**Authorization for Medical Treatment of Child**

<b>Child's Name :</b>		<b>Child's Date of Birth:</b>
Drug or Serious Allergies		
Medications		
Known health conditions		
Other information the doctor should have about your child		
<b>Person(s) who may bring child for care:</b>		
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
<b>Authorized Care:</b>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diagnosis & treatment of illness/problem	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diagnostic tests (e.g. X-ray, blood draw, etc.) recommended by the doctor	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Preventive care ("well check-up")	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Screening tests as recommended by the doctor	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Immunizations appropriate for age and history as recommended by the AAP and the ACIP	
<b>Please read each section below and initial indicating your understanding:</b>		
Initial here	This authorization is only effective for care at Cornerstone Pediatrics and does not need to be notarized. You may wish to provide your child's caretaker with a separate, notarized authorization for care elsewhere.	
Initial here	This authorization will remain in your child's record and is effective from the date signed until the child is 21 and able to authorize his/her own care. If you wish this authorization to be effective only for certain dates, cross out the previous sentence and write effective dates here: Beginning on _____ and ending on _____.	
Initial here	The person to whom you are delegating authority must provide photo ID at EVERY visit to our office.	
Initial here	You agree that we will bill your insurance plan if we have current insurance information & can verify coverage, and that you will be responsible for any amounts not covered by insurance. Insurance plans differ, and some tests, treatments and immunizations may not be covered under your plan. The person to whom you are delegating authority will be responsible to pay for any copay or fees due at the time of service unless you contact our office to make financial arrangements in advance.	
Initial here	If immunizations have been authorized above and are administered, the current applicable Vaccine Information Statements will be given to the named adult accompanying the child.	
<b>Parent/Guardian Name:</b>		<b>Date of Birth:</b>
<i>By signing here and initialing the sections above, I/we give permission for any of the persons listed above to authorize any and all medical treatments for the child named at the top of the form at Cornerstone Pediatrics.</i>		
Mom/Guardian Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____	Dad/Guardian Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____	
<b>Parent/Guardian Signature:</b>		<b>Today's Date:</b>

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Dr. Dianne McNeill, MD, PLLC dba Cornerstone Pediatrics**

**Initial History Questionnaire**

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ethnicity \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Who may we thank for referring you to our practice? \_\_\_\_\_

Reason(s) for choosing/changing to our practice: \_\_\_\_\_

Prior Pediatrician (Name/City/State) \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

<b>Allergies/Adverse Reactions</b>		Yes	No	IF YES, Please list medication & reaction
Is your child allergic to any medications?				
<b>Medications</b>		Yes	No	IF YES, Please list
Is your child on any medications? (prescription & over the counter)				
Is your child on any supplements/vitamins?				
<b>Specialty Care Providers</b>		Yes	No	IF YES, Please list
Does your child see any specialists/receive services such as PT/OT/ST, etc.?				
<b>Prenatal/Birth History</b>		Name of Hospital:		
Delivery (circle)	<i>Vaginal</i>	<i>Cesarean</i>	<i>C/S reason:</i>	
Gestational Age:	<i>Term</i>	<i>Early: _____ wk</i>	<i>Late : _____ wk</i>	
Birth Weight	Birth Length			
Discharge Weight		Yes	No	If Yes, Please Comment
Any prenatal complications for mom?				
Any maternal infections? GBS?				
Maternal Medications/Antibiotics?				
Maternal Drugs/Alcohol?				
Any prenatal complications?				
Any birth complications/meds for baby?				
Any problems after birth for mom or baby?				
Breastfeed/Pumping/Formula/Both? (circle)				Name of Formula (if any):

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Past Medical History</b>	Yes	No	IF YES, Please comment
Has your child ever been hospitalized (other than birth)?			
Has your child had any serious injuries or accidents?			
Does your child have any serious medical conditions or chronic issues?			
ADD/ADHD			
Allergies			
Anemia			
Anxiety			
Asthma/Reactive Airway/Wheeze (Circle)			
Bladder/Kidney Problems			
Blood Diseases/Bleeding Disorders			
Cancer			
Concussion			
Congenital Anomalies/Genetic Disorders			
Constipation			
Depression			
Developmental/Behavioral Disorders			
Diabetes			
Ear or Hearing Problems			
Eczema/Atopic Dermatitis/Skin Problems			
Endocrine/Thyroid Problems			
Gastrointestinal Disorders/GERD			
Headache/Migraine			
Heart Problems/Heart Murmur			
Immunizations: Is your child behind?			
Muscle/Joint/Bone Problems or Fractures			
Seizures/Epilepsy			
Vision/Eye Problems/Glasses or Contacts?			
Other:			
<b>Surgical History</b>	Yes	No	IF YES, Please list Procedure/ Approx Date/ Physician or Hospital
Has your child ever had surgery?			
<b>Developmental History</b>	Yes	No	Please comment
Has your child met developmental milestones on time so far?			
Do you have any developmental concerns?			
Do you have any behavioral concerns?			

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Family History (Biological parents, siblings, grandparents, aunts or uncles)</b>				
<i>M (Mother), F (Father), S (Sister), B (Brother), MGM (Maternal GrandMother), MGF (Maternal GrandFather), PGM (Paternal GrandMother), PGF (Paternal GrandFather), MA (Maternal Aunt), PA (Paternal Aunt), MU (Maternal Uncle), PU (Paternal Uncle)</i>				
Condition	Yes	No	Relationships*	List or Comments
ADD/ADHD				
Allergies				
Anemia				
Anxiety				
Asthma/RAD/Wheeze/Chronic Bronchitis				
Bladder/Kidney Problems				
Blood Diseases/Bleeding Disorders				
Cancer				
Congenital Anomalies/Genetic Disorders				
Depression				
Developmental/Behavioral Disorders				
Diabetes				
Ear Problems/Frequent Ear Infections				
Eczema/Atopic Dermatitis				
Gastrointestinal Disorders/GERD				
-Constipation				
-Gerd/Reflux				
-Irritable Bowel Syndrome				
-Inflammatory Bowel Syndrome (CD/UC)				
Immune problems/Immunodeficiency				
Hearing Problems/Hearing Aid				
Heart Problems/Murmur				
-Heart Attack/Disease				
-High Blood Pressure				
-High Cholesterol				
Hypo/Hyperthyroid/Thyroid				
Muscle/Joint/Bone Problems				
Seizures/Epilepsy				
Serious Illness or Injury				
Skin Problems				
Vision/Eye Problems				
Other:				

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social History			
To help us get to know you, please give us a list everyone who your child lives with:			
Mom/Guardian: _____		Employer: _____ Job Title: _____	
Phone: _____		Email: _____ Social Security#: _____	
Dad/Guardian: _____		Employer: _____ Job Title: _____	
Phone: _____		Email: _____ Social Security#: _____	
Parents Relationship: Married/Divorced/Separated/Unmarried/It's Complicated : _____			
Siblings/Stepsiblings: Names/DOB: _____			
Relatives: _____			
Other Parents: _____		Employer: _____ Job Title _____	
Phone: _____		Email: _____ Social Security#: _____	
Languages spoken in the home(s):			
	Yes	No	<i>IF YES, Please Comment</i>
Does your child go to daycare/babysitter?			Where?
Does your child go to school?			Grade: _____ Name of School:
Any concerns about school performance?			504 or IEP?
Does child participate in sports?			
Does your child participate in other organized activities?			
How many hours per day does child spend on media screen time?			(include all screens ... TV/computer/videogames)
Does your child have TV/computer/gaming station in their room?			
Does your child have a Phone?			Phone location at night? Any restrictions on use?
Does anyone smoke/vape around child?			In home?      Outside?      In car?
Does your family have any pets?			Type:
Do you have smoke alarms in your home?			Carbon Monoxide alarms?
Does your family wear seatbelts?			
Does your child use CarSeat/BoosterSeat?			Rear Facing Car Seat?
Does your child use helmet for bike/scooter?			
Does your child use sunscreen?			
Does your child use insect repellent?			
Does anyone have gun in home?			Gun locked?

List any other current concerns:

Form completed by:

\_\_\_\_\_

Name (Printed)                      Name (signature)                      Relationship to patient                      Date

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **Cornerstone Pediatrics No-Show Policy**

**PURPOSE:**

No-Show Policy has been implemented to improve scheduling opportunities and encourage patients to keep their scheduled appointments or call and reschedule or cancel their appointments in a reasonable amount of time (at least 48 hrs). As a courtesy to you, we provide reminder calls, emails and/or text messages 2-3 days prior to your child's scheduled appointment. If you fail to keep the appointment or give adequate notice of at least 48 hrs, it prevents another patient who may need the appointment and may keep them from being seen in a timely manner, leading us to need to implement this policy. This will maximize the time Dr. McNeill and our staff has to spend with your child to be able to continue to provide excellent care for your family.

**No- Show Policy:**

We have implemented this "No-Show" policy which will affect all patients who do not keep their scheduled appointment or cancel an appointment with less than a 24 hour notice.

**1st No Show-** Parent/guardian will receive a phone call or letter advising of our policy.

**2nd No Show-** Parent/guardian will receive a letter and charged a \$50 No-Show fee.

**3rd and Subsequent No Shows-** Parent/guardian will receive a letter and charged a \$50 No-Show fee and all family members may be dismissed from the practice.

No-Show for Double Appointment- Parent/guardian who schedule 2 or more children and no-show will be restricted from scheduling double appointments in the future. Parent/guardian will be responsible for appropriate missed appointment No-Show fee of \$50 per patient.

No-Show for New Patient 1st Appointment- Parent/guardian will receive a phone call or letter advising of our policy. A second New Patient No-Show will result in no further appointments being scheduled for the patient and the family will be dismissed.

Please note that the No-Show fee is not covered by insurance and is the patient/guardian's responsibility. We also understand that emergencies may occur, and should that be the case, please contact the office as soon as possible to let us know your situation and we will take that into consideration as we assist you in rescheduling your child's appointment.

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Parent/Guardian Name (printed)

Signature

Date

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **Cornerstone Pediatrics Late Arrival Policy**

**PURPOSE:**

We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient and their family deserves. Late arrivals take away our ability to provide that personalized care in a timely manner and can diminish the full experience of receiving the exceptional care in a non-rushed manner and also impact all the other families who are scheduled that day.

**Late Arrival Policy:**

Patients arriving more than 10 minutes late for a scheduled well visit, ADHD or consultation will most likely need to be rescheduled to another day, unless there is available time left in the schedule to work them back into that day's schedule.

Patients arriving more than 10 minutes late for a sick appointment will be worked back into the schedule and seen as soon as the schedule allows.

Patients who arrive early or on time will be seen before those who arrive late if we are working them back into the schedule.

We also understand that unexpected obstacles or emergencies may occur, and should that be the case, please contact the office as soon as possible with your anticipated arrival time to let us know your situation and we will take this into consideration as we assist you in rescheduling your child's appointment.

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Parent/Guardian Name (printed)

Signature

Date