PEDIATRICS & NEWBORN CARE
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www.PediatricsNBC.com

Policy & Procedures

Child's Name: _____	***DOB:*** _____
Child's Name: _____	***DOB:*** _____
Child's Name: _____	***DOB:*** _____
Child's Name: _____	***DOB:*** _____
Child's Name: _____	***DOB:*** _____

Dear Parent/Guardian:

We would like to extend our warmest welcome and thanks for entrusting your child(ren)'s care to the physicians and staff at Pediatrics & Newborn Care. Our goal is to provide you with excellent medical care in a professional, timely and friendly manner. To assist us in addressing your health care concerns efficiently and accurately, we present the following guidelines for your review.

- Patients should arrive **on time** for all appointments.
- Please note if you are more than 15 minutes late for a Well Child Check-up, your appointment will be rescheduled and we reserve the right to charge $25.
- All co-pays are due on the day of your appointment. There is a $5 administrative fee for any co-payment not made at time of service.
- There is a $10 fee for the completion of each physical or similar form, payable at the time the form(s) is/are dropped off. Letters to insurance carriers or other administrative paperwork will be charged a fee of $25, payable in advance. These fees are **not** covered by insurance. We request 2-3 business days for paperwork to be returned.
- All outstanding balances are due on the day of your appointment unless prior arrangements have been made with the practice manager.
- ***Missed Appointment Policy: Missed appointments are appointments where there is cancellations or re-scheduling within 24 hours of the scheduled appointment, or if a patient is a no-show for the appointment. There is a charge of $25.00 for each missed appointment per child, which needs to be paid prior to scheduling the next appointment. This fee is not covered by your insurance carrier. More than 3 missed appointments per calendar year may result in the patient being discharged from the practice.***

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE INFORMATION ABOVE:

X_____ _____/_____/_____
Signature **Today's Date**

_____ _____
Printed Name **Relationship to Patient**