Below are AAICSWLA's clinic policies. Our policies are meant to help our clinic run efficiently allowing us to provide the best care for our patients. Please ask our staff if you have any questions. Please initial each policy and sign below.

<u>Late and no-show policy</u>

To reschedule an appointment please contact our office at least **24 hours** before your previously scheduled appointment time. Please call to let us know if you are running late.

Appointments rescheduled or canceled within one hour of the scheduled appointment time will be documented as a "**no-show**."

Appointments rescheduled or canceled within 24 hours of the scheduled appointment time (excluding Monday appointments) will be documented as a "**same-day cancellation**."

Arriving 15 minutes early allows our clinic to run efficiently. If you are more than **20 minutes** late for your appointment, we will likely reschedule your appointment for a different day.

Patients with **three or more "no-show" or "same-day cancellation"** appointments may be dismissed from our practice.

Patients who "no-show" for their first appointment will not likely be rescheduled. New patients should complete new patient paperwork **before** their appointment time. Checkups should update any necessary insurance information **before** their appointment time.

To allow each patient the necessary time with their provider **we are not able to examine siblings or other family members** if they do not have a scheduled appointment.

Patient/parent initials: ________

<u>Medical records, medical forms, and school forms policy</u>

We will provide necessary food allergy action plans and asthma action plans to patients. **Completion of any additional school or sports forms carries a $15 charge per form**.

Completion of any **disability** and **FMLA** forms are at the discretion of the provider and carries a **$50 charge**. Completion requires 5 business days. Payment for form completion is collected when forms are dropped off.

Requests for **letters of medical necessity** or letters describing diagnoses and treatment plans are at the discretion of the provider and require ten business days for completion. Letters of medical necessity carry a **$75 charge per letter**. Payment for letters is collected before letters are provided to patients.

Patient/parent initials: ________

Patient name (printed) ________________________

Exam room and smoke odor policy

Patients and families should **refrain from eating and drinking** (water excluded) in exam rooms.

Patients and families should **refrain from using cell phones** while the nurse or provider is in the exam room, including talking on the phone and taking photos/videos.

We understand that children can get restless while waiting for the nurse or provider. If trash or food or liquids are spilled, we ask patients and families to do their best in helping to **keep our exams room clean.**

Strong tobacco or marijuana smoke odor in our waiting room and exam rooms make it difficult for our staff, providers, and patients (especially children) using the same room. We understand that quitting smoking can be extremely difficult but it is the single best thing smoking patients can do for their own health.

Patient/parent initials: ________

Patient insurance and financial policy

Our staff does their best to verify patients' insurance coverage. However, **insurance verification by our staff is not a guarantee of coverage.** It is important that patients are familiar and comfortable with the contract they have with their own insurance company.

We require patients to have insurance / pharmacy cards for every appointment or service visit. As a courtesy we will bill your insurance and collect the patient responsibility amount at the visit.

It is the patient's responsibility to inform our business staff of ANY insurance changes. Otherwise, patients may be responsible for payment in full for all services rendered.

Payment for co-pays, deductibles, co-insurance payments, or non-covered services are due at the time of service. Our clinic accepts cash, debit cards, most credit cards & personal checks.

Patients are responsible for all fees associated with non-sufficient funds (NSF). Returned checks will be charged to the patient's account as well as an additional $50 service fee.

Outstanding balances are due within 30 days. We offer payment plans if necessary.

Balances exceeding three months and without a started payment plan will go to collections. No future appointments will be scheduled until the full balance is paid.

Payment and updated insurance information at the time of service is the **responsibility of the accompanying adult – not another parent.**

Patient/parent initials: ________

Patient name (printed) ________________________

Patient dismissal policy

Patients can be dismissed from the practice for the following reasons:

1. Three or more “no-show” or “same-day cancellation” appointments

2. Not complying with their prescribed medical care

3. Being disrespectful, hostile, or verbally/physically abusive to **ANY** clinic staff at any time.

4. Not paying for services

A patient who is dismissed from the practice will be notified via a letter send by certified mail and regular mail to the address of record.

Following dismissal, a patient will be provided with any necessary emergency care for 30 days starting from the date the dismissal letter was mailed.

Patient/parent initials: ________

Telephone and correspondence policy

Our staff does their best to return phone calls the same day. Messages are returned typically at lunch time and at the end of the day. Repeated phone calls will not expedite a return call.

Complex/new issues may require scheduling an appointment instead of a nursing phone call.

If you have not heard about your lab results one full week after having labs drawn, please call the office. Sometimes labs do not send us timely results. We may not know when or where you had labs drawn.

Please check for remaining medication refills with your pharmacy **before** calling the office.

Do not send medical information or questions to ANY of our office email addresses. **We do NOT treat patients or answer questions via email/patient portal.** Please call us.

Patient/parent initials: ________

Acknowledgement

I have read and I understand the above policies of AAICSWLA. I agree to the above policies.

______________________________	_______________	_______________
Signature of patient/parent/guardian	Relation to patient	Date

Patient name (printed) _________________________