ORCHARD PARK FAMILY PRACTICE, PC
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OFFICE POLICY

We at Orchard Park Family Practice are committed to providing you with the best possible care and would be happy to discuss our policy with you at any time. Your clear understanding of our Financial Policy is important to our Professional Relationship. Please ask if you any questions regarding our fees, financial policy or your financial responsibility.

Cancelled, Re-scheduled, and No-Show appointments:

The patient is required to notify our office at least 24 hours in advance of an appointment they wish to cancel or reschedule or it is considered as a NO SHOW. If the patient is 15 minutes late for their appointment, it is considered a NO SHOW and they will be required to reschedule. If the patient NO SHOWS for (1) appointment the patient will be billed a $25 fee. A subsequent (2nd) NO SHOW appointment in 12 months will be billed $50. A third NO SHOW appointment in 12 months will be billed $75. A patient will be reviewed for release from our practice for failing not to show for appointments.

Patient Forms:

The patient will be required to pay a $20.00 fee for any forms that re required to be completed. (Disability, FMLA, etc.)

Worker's Compensation:

As of April 1, 2011 our office no longer accepts Worker's Compensation cases; new or old. If you are seen for an illness or injury that is Worker's Compensation related **you will be responsible for the payment of services** as these charges cannot be billed to your insurance.

Parental Refusal of Immunizations:

We at Orchard Park Family Practice are dedicated to providing the best care that we can for our patients. We feel to do this effectively we must enter into a partnership based on mutual trust with the parents of our patients so that together we can achieve this goal. Recently, there has been trend of unjustified fear of side effects from vaccines by well-meaning parents. We believe that immunizations are one of the most important health interventions a parent can do on behalf on their children, and we want all of our patients to benefit from this modern lifesaving tool.

While we recognize and respect the parents' role as the ultimate decision maker for their child's healthcare, we believe strongly that we are obligated to deliver the best and safest healthcare possible for our patients and our community. We feel professionally uncomfortable caring for

children who will not receive vaccinations recommended by the New York State Department of Health, the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics and the American Academy of Family Physicians. These preventable diseases can and do cause severe illness, brain damage and death. Although we strongly support all recommended vaccines, there are series that we must insist that our patients receive in a timely manner to remain or become a patient in our practice.

The vaccines are: Diphtheria, Tetanus and Acellular Pertussis (DTaP/Tdap); Haemophilus Influenza Type B (Hib); Hepatitis B (HBV); Measles, Mumps and Rubella (MMR); Polio (IPV); Meningococcal (Menactra – MCV-4); Rotavirus; Varicella (Chickenpox); and Pneumococcal Conjugate Vaccine (Prevnar). While we believe that vaccines are very safe, and clearly safer than not having vaccines, we recognize that there are risks associated with all interventions and therapies.

As a group practice, we feel we must implement a consistent policy in regards to Parental Refusal of Immunizations. Refusal of these vaccines indicates a significant difference of philosophy of care, and we regretfully inform you that we will not be able to provide medical care for your child or family. We ask that you find another medical provider who will accommodate your views and practices. We thank you for your understanding and will continue to provide you with the best evidence based and preventative health care available.

Insurance Participation and Financial Responsibility:

It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements as well as network providers if applicable. Insurance information must be given to us within 30 days of the date of service, as we only have a certain time frame to submit a claim to your insurance on your behalf. We will bill insurance companies as a courtesy to you. If we have not received payment from an insurance company within 60 days of the date of service, you will be expected to pay the balance. We provide you with all necessary information to submit your claim to your insurance company. We will not become involved in any disputes between you and your insurance company re: deductibles, co-payment, secondary or tertiary insurances, co-insurance, covered charges etc. other than to supply them with necessary factual information.

Payment Due at Time of Service:

Insurance co-payments are to be made at EACH visit. Failure to do so will result in an additional $5 surcharge. Our practice accepts cash, personal check, Discover, MasterCard, American Express and Visa. There is a service charge of $15 for returned checks. The office does give patients with no insurance a 20% discount only if the balance is paid at the time of service. If you have a high deductible insurance policy you are required to pay $50 at the time of service for each appointment and we will bill you for the remaining balance, NO EXCEPTIONS.

Custodial Parent Responsibilities:

The custodial parent is responsible for payments at time of service whether the child has insurance or not. The office will not get involved with % breakdowns such as one parent being responsible for 20% and the other parent 80%. It is the parent's responsibility to work out an agreement for payment-in-full at time of service.

Assignment of Benefits and Consent for Treatment:

I hereby assign all medical benefits to include Major Medical benefits to which I am entitled, including Medicare, private insurance and any other plan to Orchard Park Family Practice, PC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize my physician to perform any medical treatment as deemed necessary.

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that, unless I maintain the agreed-upon payment agreement, my account may be turned over to a collection agency. If my balance should go to collections, I am aware that I will incur an added fee of up to $50.00 to cover the collection company's fee.