Pediatric Associates of Alexandria

HealthPlex Office
6355 Walker Lane, Suite 401
Alexandria, VA 22310

Potomac Yard Office
3600 S. Glebe Rd., Suite 150
Arlington, VA 22202

Tel: (703) 924-2100
Fax: (703) 922-6067

www.pedsalex.com
www.healthychildren.org

PATIENT INFORMATION

Office Hours

- **Monday- Thursday** **6:00 am - 8:00 pm (Both Offices)**
- **Friday** **6:00 am - 6:00 pm (Both Offices)**
- **Saturday** **8:00 am -12:00 pm (Healthplex office only)**
- **Sunday** **8:00 am- 12:00 pm (Potomac Yard office only)**

- All of our appointments do not have a grace period. If you arrive for your appointment late, it will be necessary to reschedule your appointment due to time constraints.
- You will be assessed a missed appointment fee of $50.00 per missed appointment.
- Sick and Well Visits can be scheduled via our patient portal and Healow App. Please see a representative for more information

Immunization Appointments Are scheduled Tuesday thru Thursday between the hours of 8:00 am-5:00.

Missed Appointments If you miss a scheduled appointment with us and did not call with at least 24 hours advance notice, there will be a $50.00 Missed Appointment fee charged to your child's account. Missing three scheduled appointments may terminate your relationship from the practice.

Sibling Appointments For check up appointments and sick visits, siblings are scheduled in different consecutive time slots. We ask that you do not bring a sick sibling in (who does not have a scheduled appointment) with a child who has a scheduled appointment, as this causes the physicians and nurse practitioner to run behind.

Routine Check Ups Well check appointments are 20 minutes and are limited in our daily schedule, therefore, we recommend that you call a minimum of 2-3 weeks in advance to schedule your child's next well check appointment.

Insurance **Each calendar year we ask that new demographic forms to be completed and signed as well as copies of each patient's insurance card. Insurance mandates as well as HIPAA requirements. All patients or their guardian are asked to sign that they were given our HIPAA guidelines.**

Co-payments/ Deductibles/Coinsurance/Past Due Balances If your insurance plan requires you to pay a co-payment, it is due at the time of your visit. There are no exceptions. Any balance on your account will also be collected at this time. Staff will inform parents of past due balances on their account. I understand and agree to pay an assessed $10.00 late fee for each co-payment not paid at the time of visit.

There is a $50 fee charged for returned checks.

Insurance Referral Process: Please be advised that if your insurance company requires a referral, we will need three (3) to five (5) business days to complete this process. The referral can be found on our website. It is the parents' responsibility to schedule an appointment with the specialist, ensure that the specialist participates with their insurance AND allow us adequate time to generate the appropriate referral for your visit. The parent must notify our referral specialist with the date of the appointment, the name of the specialist and their office location, so that a referral can be generated. It is the parent's responsibility to pick up the original referral form from us (if required by the insurance company) before seeing the specialist. Do not go to the specialist office without a referral if it is required by your insurance carrier. For additional information please call our referral specialist or your insurance carrier. REFERRALS CANNOT BE BACK DATED.

Prescription Renewals: When prescription refills are needed, please call your child's pharmacy to see if there are any refills left. If not then ask the pharmacist to call us. WE DO NOT MAIL PRESCRIPTIONS, ESPECIALLY CONTROLLED SUBSTANCES. Therefore, it is not advisable to wait until the last dose has been given to your child.

Emergency Referral Info: If you are out of town and your child requires emergency treatment, you do not need to call our office to get a referral. Please refer to your insurance handbook and review the section on out-ofarea network emergency visits. You can also call your insurance carrier for instructions; their telephone number should be listed on the back of your insurance card.
Please make sure to call our office upon your return so that we can log your child's chart and/or to schedule an emergency follow up visit.

Allergies: At your office visit, always let the nurse know (before being seen by the physician or nurse practitioner) if your child has any known medical allergies.

Medical Records are retained only up to the age of 21 years. Remember to request your child's shot records prior to age 21.

Negative Test Results: Our policy regarding routine laboratory test results is that the parent will be notified only if the tests are abnormal. You may call and get the results if you wish; however please allow ample time for the results to come back to our office from the lab.

Our advice nurses are available M-Th 6am-8pm, Friday 6am-6pm, Saturday and Sunday 8am-12pm to answer telephone calls of a medical nature. If necessary, one of the physicians will return your call later that day.

Specific Provider Requests: We suggest you meet all the health care providers in our group. Should you prefer anyone in particular, we will try to accommodate your wishes. When possible, follow-up visits for the same illness can best be handled by the original person treating your child. Please inform the person scheduling your appointment if you prefer a specific provider. If possible, they will try to accommodate your request.

After Hours Calls: Our practice offers after hours assistance EVERY, night, weekend, and holiday for emergency calls only, WE ask that all routine, non-urgent or non-dangerous concerns be reserved for regular office hours. **There is a $20.00 After Hours Fee assessed to your child's account for all after hour calls to the after-hours system that is NOT billed to insurance.**

Patient Balance Due/Collection Agency: Upon payment from your insurance plan, remaining balances are to be paid upon receipt of the statement. Unless a previous financial payment schedule has been established with our office, any balance that is not paid within 60 days may be turned over to our collection agency. At our discretion, delinquent accounts may be terminated from our practice.

Transfer of Medical Records: A **medical record release of information** form must be completed prior to the release of all medical information. You can obtain a release form from our office or on line at www.pedsalex.com. After the request has been received, you will be contacted by our medical records department for any additional information needed and to obtain payment. Please allow up to 14 days to complete the process. There is a processing fee for medical records, but can also be accessed free of charge through the patient portal app.

Parental Authorization Form: When you cannot accompany your child for treatment, we have a form letter available for you to complete prior to your child's visit that authorizes treatment and/or immunizations. The completed form will be kept in your child's chart.

Pediatric Associates of Alexandria
Vaccine Policy 01/01/2016

Pediatrics Associates of Alexandria (PAA) is a large practice, caring for thousands of children. Every day, we have hundreds of children coming in and out of our office. Some are too young to be vaccinated and are therefore vulnerable to severe, potentially life-threatening infection. It is our duty to protect each of our patients to the best of our ability from any infection that could be contracted in our office.

Due to recent concern of highly contagious, vaccine-preventable illnesses in our region, PAA is revising our vaccine policy. This is being done to better protect all our patients, as well as their caregivers and our greater community.

Effective **January 1, 2016**, patients at PAA will be **REQUIRED**:

1. To start required* childhood immunizations at 2 months of age, unless there is a medical contraindication.

2. To complete required* childhood immunizations no later than 2 years of age, unless there is a medical contraindication.

3. To complete immunization boosters required* after the fourth birthday by 6 years of age, unless there is a medical contraindication.

4. To complete immunization boosters required* after the tenth birthday, within 1 year after the latest recommended date for administration, unless there is a medical contraindication.
5. Children who are behind in their vaccines will have 30 days to initiate the catch-up process, and 6 months in which to receive all needed additional vaccines.

Immunization status will be reviewed and discussed at office visits with a provider.

This policy will be updated should any new recommendations/requirements arise as determined by authorities including the CDC, AAP, ACIP, or the State of Virginia.

Legal guardians who are not able to abide by the above guidelines will be asked to find a medical practice that is able to comply with their beliefs.

Pediatric Associates has no greater responsibility than to protect each and every one of our patients. Having a fully immunized patient population is essential to our providing this protection.

*Required vaccines are those required by the State of Virginia for school entry. These include DTaP, HIB, IPV, Prevnar, Hepatitis B, MMR and Varicella. See http://www.vdh.virginia.gov/epidemiology/Immunization/requirements.htm for details.

AAP 2015 immunization schedule:
http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

A Commitment to Our Patients about Antibiotics

Antibiotics only fight infections caused by bacteria. Like all drugs, they can be harmful and should only be used when necessary. Taking antibiotics when you have a virus can do more harm than good: you will still feel sick and the antibiotic could give you a skin rash, diarrhea, a yeast infection, or worse.

Antibiotics also give bacteria a chance to become more resistant to them. This can make future infections harder to treat. It means that antibiotics might not work when you really do need them. Because of this, it is important that you only use an antibiotic when it is necessary to treat your illness.

How can you help? When you have a cough, sore throat, or other illness, tell your doctor you only want an antibiotic if it is really necessary. If you are not prescribed an antibiotic, ask what you can do to feel better and get relief from your symptoms.

Your health is important to us. As your healthcare providers, we promise to provide the best possible treatment for your condition. If an antibiotic is not needed, we will explain this to you and will offer a treatment plan that will help. We are ***dedicated*** *to prescribing antibiotics* ***only*** *when they are needed, and we will avoid giving you antibiotics when they might do more harm than good.*

If you have any questions, please feel free to ask us.

Sincerely,

GET SMART
Know When Antibiotics Work

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS270414

CONDITIONS OF REGISTRATION

THE PRACTICE CONSENT FOR TREATMENT

Pediatric Associates of Alexandria, Inc. and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons I agree to pay any applicable charges for having records copied. Please be aware that medical records can be obtained through the patient portal or Healow App FREE of charge.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT

I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by my children, stepchildren or any other extended family members, I (we) are financially responsible for; including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or conformation. I understand that I am responsible for and agree to pay the $10.00 late fee for each co-payment not paid at the time of visit. I understand that I am responsible for and agree to pay a $25.00 Late Missed Appointment Fee for all scheduled appointments that I was more than 15 minutes late for. I also agree to pay a $50.00 Missed Appointment Fee for all Missed Appointments or that were not cancelled with at least 24 hours advance notice. I understand that missing three scheduled appointments may terminate my relationship from the practice. I understand that I am responsible for and agree to pay a $30.00 "Emergency After Hours fee" for all after hour's calls to the covering provider. These after hour calls are considered an emergency; and will be charged to the member's account on the date services were rendered. The after-hour calls are not covered by commercial and or Medicaid policies and are the member's responsibility. I understand that I am responsible for and agree to pay an administrative fee for each form I request to be completed. I understand that I am responsible for the entire balance in my child's account; including copayments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason. I understand and agree that I am expected to pay all balances within 30 days of services being rendered. I understand and agree that if for any reason my personal check is returned for any reason, including insufficient funds on my account I will be assessed and responsible for a $50.00 Returned Check Fee in addition to ALL original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. PAA is required to report all services rendered, to your insurance carrier; even those that occur outside of normal business hours (M-F 8am-4:50pm). I understand that I am responsible for and agree to pay all balances rendered patient responsibility by my primary insurance carrier.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

Information ***Insurance info and copy of insurance cards needed to file for benefits.***

I agree to terms & conditions of registration. I certify that the information I have reported is true and correct. As the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on the Conditions of Registration Form. *****In cases of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring the child(dren) in for exams, and have full access to the child's medical records. If you have any concerns in this area, please contact the office supervisor for further questions.

Signature of Parent/Guardian/Guarantor	Print Name-Relationship to Patient	DATE:

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Authorization for Treatment and/or Immunization of Minors

In absence of parents or guardians

Today's Date:_____

Patients' Names: Date of Birth

_____

_____

_____

I hereby authorize treatment of the above child(ren) and give permission for treatment during my child's preventive medical examination or sick examination. This form remains in full effect until rescinded in writting by parent/legal guardian.

The following person(s) listed below are authorized to bring my child(ren):

Name: Relationship:

_____

_____

* All persons selected to bring your child to our office must be 18 years of age or older and required to show a current photo ID.

- ☐ Pediatric Associates of Alexandria follows the recommended immunization schedule of the American Academy of Pediatrics. I give permission for the administration of the recommended vaccines.
- ☐ I hereby request no immunizations be given to my child at their examination.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name: _____

- ☐ My child is 16 years of age (or older) and has a current driver's license. I give Pediatric Associates of Alexandria authorization to treat my child for; preventive medical examination, vaccine administration, and/or sick visits.

If a provider needs to call me while my child is being seen you can contact me at:( )_____.

This form remains in full effect until rescinded in writting by parent/legal guardian.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name: _____

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Billing Department
Tel: 703-778-5500

CREDIT CARD CONSENT FORM

Dear Patients,

This letter is to inform you of our updated billing practice regarding receiving patient payments. We now use a Credit Card Merchant Service called Open Edge, which gives us the ability to swipe your credit card, debit card, or health saving account card to accept payment in the office and have the number securely stored on a remote server with OpenEdge.

We want to assure you that our software has been thoroughly vetted according to the strict data retention rules required by the merchant processing system. The only information stored at our office in our secure, encrypted system, is the name on the card, the expiration date, and the last 4 digits of the card number.

We require your credit card information to be stored for future payment for some of the following reasons:

- **Your insurance company may not reimburse us for medical services or only make partial payment, because of the following:**
  - **Deductible has not been met for the current calendar year**
  - **Co-insurance may be applied to the charges**
  - **Service may be deemed as not a payable benefit for your plan.**
  - **Policy has terminated, or there is a gap in coverage.**
  - **Newborn has not been added to the policy and are not covered under parent's benefits.**
- **You may have a copayment for medical services.**
- **You wish to set up a payment plan for a large balance on account**.

AUTHORIZATION

By signing below, I authorize Pediatric Associates of Alexandria, Inc. to keep a credit card on file for future payments and to charge all balances accrued on the patients listed below with the information saved. **Please be advised your card will be charged the amount on your statement within 5-7 business days of statement date.** I am aware that if any of my personal information has changed, I am responsible to notify Pediatric Associates of Alexandria, Inc. of the change(s) to ensure they have the most current information to contact me or process payment accurately.

*****PLEASE LIST ALL CHILDREN ON FORM*****

Name of Child(ren)	DOB	Acct #

Credit card information:

Cardholder Name: _____

Credit Card Number: _____ Exp Date: _____ CVV: _____

Parent or Guardian Name (Print): _____

Parent or Guardian Signature: _____ Today's Date:_____

☐ I have reviewed and understand Pediatric Associates of Alexandria, Inc Financial Policy and Notice of Privacy Act