SG Pediatrics of Lake Orion

Office Policies

Office Hours
Our office is open Monday-Friday 9:00-5:30 pm. *by appointment only,* and Saturday from 9:00-12:30 pm.

Reaching the Doctor after Hours
If there is a life threatening emergency, call 911 or go to the nearest emergency room. For urgent phone calls you may call the answering service directly at (248) 858-6885 and they will page the doctor on call for you.

Prescription Refills
If you need a refill on any of your prescriptions (except controlled substances), please call give us three (3) days notice.

Faxing of Medical Information
Due to the Health Insurance Portability and Accountability Act (HIPAA), we are not able to fax any medical information. This includes immunization records and physical examination information.

Late Appointments
Please notify our office as soon as you know you will not be able to keep your scheduled appointment. If you will be more than 15 minutes late we will need to reschedule the appointment so that other patients can be seen timely.

Missed Appointments
It is very costly to our practice when patients miss their appointments without notifying us. As a courtesy we alert you of an upcoming appointment with a phone call reminder, however, please make sure it is put on your calendar as you make the appointment. If you are a no-call-no-show for a 2nd time, we will charge $25 for the missed appointment. If you a no-call-no-show for the 3rd time, we will charge $25 and you risk discharge from the practice.

Referrals
To make the referral process as painless as possible for you, please notify us of your appointment date as soon as possible so we can ensure the referral is ready on time. Referrals require 5-7 business days. This time is necessary in case your insurance needs further information or time to review the case before giving authorization for the requested services. Referrals will be faxed to the specialist's office when completed and should be there when you arrive for your appointment. **Except for in emergency situations, last minute referrals will not be done.**

Emergency Room Visits
Per directives from your insurance company, only life threatening emergencies should be seen in the ER. Urgent care visits are for after- hours or holidays for issues that can't wait until the office opens.

Co-pays & Balances
Co-pays are expected at the time of service. In case of divorce, according to Michigan State Law, the parent bringing the child in for treatment is responsible for the payment at the time of service. Any accumulating balances need to have regular payments made each month. For a payment plan, please talk with our front desk staff. Credit cards can be kept on file for your convenience.

Release of Medical Records
To obtain a copy of your child's medical records, we must receive written consent. There is a $15 charge for medical records (unless a large quantity of pages which would mean additional charges) and a $5 for minimal records. This charge, allowable by the State of Michigan, is to cover administrative and supply costs.

SG Pediatrics of Lake Orion

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your PCP as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialist, if preauthorization is required prior to a procedure, and what services are covered.
5. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your visit. For scheduled appointments, prior balances must be paid prior to the visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service.
8. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
9. If previous arrangements have not been made with our billing company, any account balance outstanding greater than 28 days will be charged a $5 re-bill fee. Any balance over 90 days will forwarded to a collection agency.
10. If you participate with a high-deductible plan, we require a copy of the health savings account debit/credit card to be kept on file.
11. We require prior notice for canceling any appointments, preferably more than 24 hours for physicals. There is a $25.00 charge for missed appointments on the second NCNS.
12. A $25.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
13. We charge $15.00 or more per child to copy or transfer medical records.
14. If your child has school, camp, or sport forms to be completed, there is a $5.00 charge per form is not completed at the time of the physical.
15. Not all services and vaccines provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____ Relationship _____

Responsible Party Member's Printed Name _____

Responsible Party Member's Signature _____ Date _____