Office Policies

13643 S. Mur-Len Rd.
Olathe, KS 66062
913-764-7060

Preferred Pediatrics

Effective 1/01/2025

- **Insurance:** It is your responsibility to provide us with the correct insurance information at each visit. You are required to bring a copy of your current insurance card with you each time you visit our office. If we do not have accurate insurance info you may be responsible for all fees. As a courtesy to our patients, we will file your insurance. If insurance information is not provided or not active, payment is due at the time of service. We do not file insurance on liability claims (car accidents, injuries at school, etc.).
- **Insurance Benefits:** Become familiar with your insurance policy deductible, copays, and benefits. Does your policy cover well visits, Immunizations, and lab work? It is your responsibility to understand what your insurance covers.
- **Forms:** Forms for camps, sports, and school should be filled out at annual well visits. We require all personal information to be filled out on forms before we can complete and sign them. You can print a copy of a physical or sports PE form on our website to fill out and submit. Forms that need to be filled out between annual well visits may be subjected to a fee. We require 24 hours to get a signed form back to you outside of well visits. **FMLA** or other more detailed forms require a **$25** fee and may take 2-3 days to return. There is no charge for WIC forms or forms for children on state insurance.
- **Prescriptions:** We will give you enough meds/refills to last until your next well visit. If refills are needed between well visits please have your pharmacy contact us. Medication changes or other refills require an office visit.
- **Controlled Substance Prescriptions:** Any child receiving controlled substance prescriptions (ADHD meds) is required to be seen in the office every three months. Prescriptions will be given for 3 months at a time. Prescriptions will not be refilled or changed between visits unless this was part of the plan discussed at the visit. We will need 24-48 hours to refill these prescriptions.
- **Telephone Calls:** Our office phones are staffed from 8:30 to 4:30 Monday-Friday. Our staff will happily answer your questions or concerns. **After-hours calls are forwarded to a nurse triage service. There will be a $15 fee for using this service.** We share in the cost with the families, as Children's Mercy charges our office for each phone call they receive from our patients.
- **Well Visits:** We require that our patients stay current on well visits per the AAP-recommended schedule. Annual well visits are required after age 3. There may be a co-pay or additional charge for any concerns addressed that fall outside of a normal well visit.
- **Immunizations:** We require our patients to stay current on all state-required immunizations unless there is a MEDICAL contraindication.
- **Medical Records:** Upon written request, we will transfer a copy of your child's growth chart, immunization record and last well visit. If more records are needed a charge will apply.

- **Missed Appointments:** There will be a **$50** charge for any appointment missed or canceled without a 24-hour notice. We provide a text reminder service for all well visits. Failure to receive this text does not excuse you from responsibility for your appointment. If your schedule changes and you cannot keep your appointment please let us know at least 24 hours in advance out of courtesy to our staff and other patients waiting to schedule. If your child is sick at the time of a scheduled well visit please give the office a call so we can decide if the well visit needs to be changed to a sick visit or rescheduled. Fees will not apply for visits canceled less than 24 hours in advance due to severe weather alerts.

- **Newborns:** Please add newborns to your insurance policy immediately. Many insurance companies allow 30 days to add your newborn baby. If you wait, it delays payment of your claims. Call your insurance prior to see what information they will need. Birth Certificate, SSN, etc.
- **Card on File:** We require a card on file (Debit, Credit, HSA, FSA, or HRA.). This card is encrypted and stored by a secure payment processor.
- **Payments:** **Copays are due at the time of service**. This is part of your contractual agreement with your insurance. You are responsible for paying what is not paid by insurance. Once your insurance has processed a claim you receive an EOB that will explain your financial responsibility. Accounts with no payment for 60 days may be turned to our collection agency. If your account is turned over to a collection agency, a 15% collection charge will be added to cover the collection fees. Every parent or guardian is responsible for payment at the time of visit, for any services provided to his or her dependent child regardless of any outside agreement with another parent or guardian. You may incur a charge if a statement is returned to us due to an incorrect address on file, if a card is declined for payment, or if there are insufficient funds to cover a check. This charge will be added to your balance due.
- **HMO Contracts & Kancare:** Please check your insurance card or with your insurance customer service department to make sure you are assigned to our physicians. If we see you and you are assigned to another physician, you may be responsible for the bill.
- **Billing Questions:** The business office staff is available to answer any questions you might have regarding your account. Our business office phone number is 913-764-3016.
- **Notice of Privacy Practices (HIPAA):** I understand the Notice of Privacy Practices documents are made available to me regarding HIPAA. I understand that I have the right to ask for a complete copy of these documents for evaluation and they are available at any time on our website www.preferredped.com

(Please list all family members with first and last names as seen at Preferred Pediatrics)

Patient Name _____ **DOB** _____ **Patient Name** _____ **DOB**_____

Patient Name_____ **DOB**_____ **Patient Name** _____ **DOB**_____

Patient Name _____**DOB** _____ **Patient Name** _____**DOB**_____

Patient Name _____**DOB** _____**Patient Name** _____**DOB**_____

By signing below, I acknowledge understanding of all of the policies listed above

Print Name (first and last): _____

Signature: _____ **Date:** _____

(Signature of parent or legal guardian if patient is less than 18 years old)

This Agreement is Effective for 2 years from the Date Above