

CARRBORO PEDIATRICS AND INTERNAL MEDICINE POLICIES AND CONSENT

Patient Name(s) & DOB: _____

Thank you for choosing Carrboro Pediatrics and Internal Medicine as your medical home. We provide care for both pediatric and adult patients. The following document outlines our office policies. By signing below, you acknowledge that you have reviewed, understand, and agree to abide by these policies.

Please initial in the blank space before each section - By initialing you agree to have read, understand, and abide by the following policies:

____ **PAYMENT** - Copays, deductibles, and outstanding balances are expected at the time of service. Please be prepared to present your insurance card at each visit. If you are unable to provide your insurance information or required payment, you may be asked to reschedule your appointment. We participate with many insurance plans and will submit claims on your behalf. If your insurance plan is out-of-network with our practice, payment will be required at the time of service, and we will provide documentation for you to submit to your insurance company.

____ **MISSED APPOINTMENTS** - We request at least 24 hours' notice to cancel or reschedule an appointment. This allows us to offer the appointment time to another patient. If an appointment is missed or cancelled with less than 24 hours' notice, a **\$75.00 No Show fee** may be charged to your account. This fee is the responsibility of the patient and is not reimbursable by insurance. Repeated missed appointments (3 or more without appropriate notice) may result in dismissal from the practice.

____ **LATE ARRIVALS** - Patients who arrive late for their scheduled appointment may be asked to reschedule depending on provider availability and the clinic schedule for the day. In general, patients arriving **more than 10 minutes late** may not be able to be seen as scheduled. If a late arrival can be accommodated, the visit may be shortened to allow the clinic to remain on schedule for other patients. If the appointment must be rescheduled due to late arrival, it may be treated as a missed appointment, and the **\$75.00 No Show fee** may apply.

____ **MEDICAL RECORDS** - If you or your child are transferring care from another practice, we request that medical records be sent prior to your first appointment whenever possible. A completed medical records release form with the previous provider's name and address will be required. Your medical records are confidential and will not be released without your written authorization except as permitted by law. Requests for records to be sent to another physician or medical practice will be processed within 30 days. Requests for copies of records for personal use, legal purposes, or insurance matters may require up to 48 hours to prepare and will incur a **\$10.00 medical records copying fee (additional fees may apply)**. Completion of forms such as school or simple employment forms may incur a **\$10.00 form completion fee** and may require up to 7 business days for processing. More **complex forms may cost up to \$50** depending on time required to complete.

____ **HIPAA NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS** - I acknowledge that I have reviewed the *HIPAA Notice of Privacy Practices and Patient Rights* and understand how my health information may be used and disclosed.

____ **CODE OF KINDNESS** - I acknowledge that I have reviewed and agree to the *Code of Kindness*.

____ **RECORDINGS** - Audio or video recordings of appointments are not permitted without prior consent from the provider and staff.

____ **VACCINES** - Carrboro Pediatrics and Internal Medicine believes immunizations are a critical part of preventive healthcare. For pediatric patients, adherence to the recommended vaccination schedule is expected unless medically contraindicated. Families who are not already established patients of the practice who choose not to vaccinate their children may be asked to seek care at another practice.

____ **WELL VISITS AND ADDITIONAL SERVICES** - Insurance plans define what services qualify as preventive or well visits. If additional concerns, new problems, or management of chronic conditions are addressed during a preventive visit, your insurance may apply a copay, deductible, or additional charge.

____ **UP-TO-DATE PREVENTIVE CARE** - We encourage all patients to remain up to date with recommended preventive visits and screenings. In order to maintain continuity of care, some services (such as medication refills or same-day appointments) may require that patients remain current with their routine visits.

____ **PRESCRIPTION REFILLS** - Prescription refill requests will generally be processed within three business days. Refills may be denied if the patient is overdue for a follow-up appointment or preventive visit. For safety reasons, certain medications require periodic evaluation before refills can be authorized.

CONSENT TO TREAT - As an adult patient, or as the parent or legal guardian of a minor patient, I authorize Carrboro Pediatrics and Internal Medicine and its providers to perform medical evaluation, treatment, diagnostic testing, and preventive services deemed medically appropriate.

FOR PEDIATRIC PATIENTS, I authorize the following individuals to bring my child to appointments and consent to medical treatment, including vaccinations, when I am not present. These individuals may be required to present identification.

NAME

RELATIONSHIP TO PATIENT

NAME

RELATIONSHIP TO PATIENT

PATIENT / GUARDIAN AGREEMENT - I have reviewed, understand, and agree to abide by the policies outlined above, including the HIPAA Notice of Privacy Practices and Patient Rights. I understand that I may request a copy of these policies at any time.

NAME

SIGNATURE

RELATIONSHIP TO PATIENT

DATE