HEALTH ONE, INC

"Your Pediatric Home"

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HEALTH ONE OFFICE POLICIES

INFORMATION COMMONLY ASKED ABOUT:

Taking care of your child and insuring their best interest at all times is first and foremost. We are honored that you have chosen Health One to be your partner in the co-ordination of your child's health care. This is a team effort that requires the parent and the provider to communicate well at all times. In an effort to get off on the right foot together we have put together this general office policy guideline. These guidelines are designed in an effort to make the entire experience run as smoothly as possible given all the factors involved at home and in our industry. While we are not able to list every procedure and guideline that may apply, below are some of the most commonly occurring issues to help set the spirit of understanding.

Waiting Room – Through years of experience we have developed a system of scheduling that provides as much consistency to you as possible and maintains a manageable workflow. Being that we see well patients and patients that are sick there can be treatment and emergency events that interfere with the daily schedules. We appreciate that your time is also valuable and do everything possible to see that your appointment is handled as efficiently as possible. If there are issue's of insurance change, balances that need attended to our any other administrative issue that may need attended to we ask that you arrive 15 minutes early as to not run into our 10 minute late policy.

BILLING & INSURANCE:

We accept most insurance plans and make every attempt to verify your current eligibility. Because things change frequently between you, your health plan, and your employer we ask that you **BRING YOUR INSURANCE CARD TO EVERY VISIT** as you will be asked by our receptionist to verify coverage **AT EVERY VISIT!** Insurance benefits can vary from plan to plan, therefore having full knowledge of your coverage can help eliminate billing problems and misunderstandings. We will always verify for you that you have coverage, and are eligible but we are not the insurance company and can't interpret your benefit coverage. **If you have any benefit questions please call your insurance company.** Your insurance is a contract between you and your insurance company, our office is not part of this contract. **Please be aware that ultimately you are financially responsible for any services which are not covered by your insurance policy. If you are unsure as to what services are covered by your plan, please contact your insurance provider prior to your appointment with us.**

"C.O.B"(Coordination of Benefits) – EVERY YEAR, usually the calendar year, your insurance company stops paying claims until you verify WITH THEM, that you do or do not have other insurance coverage. You can do this by completing a form provided by your insurance company or by phone using the number listed on your ID card. If you don't do this and come in for an appointment before verifying this with you insurance company, they will deny the first claims of the year and any thereafter until you have done this. We will not be able to schedule you until this is done or you self- pay for the visit.

If we get notice of that any claim is has been denied because of this, we will not be able to schedule an appointment until this is taken care. If you have an emergency and need care but the COB issues is still outstanding you will be required to pay in full at the time of service.

Commonly referred to as an "E.O.B" an explanation of benefits is a statement sent by a health insurance company to a covered individual explaining what medical treatments and/or services were paid for on their behalf. An EOB typically describes:

- The payee, the payer and the patient
- The service performed- the date of service, the description and/or insurer's code for the service, the name of the person or place that provided the service, and the name of the patient.
- The doctor or facility's fee, and what the insurer allows (In Network) – the amount initially billed by the doctor or facility, minus any deduction applied by the insurer in the adjudication of the claim respective o the benefits you have.
- The amount the patient is responsible for
- Adjustment reasons and codes
- EOB documents are protected health information (PHI) under the affordable care act.

When your insurance company processes your claim they send an EOB to you and to the provider of the service

Self-pay: All patients who present without valid insurance coverage information are considered a self-pay (SP) patient. SP patients are expected to pay charges at the time of service. If you have insurance coverage but are unable to provide valid proof and we can't verify eligibility at the time of service, **payment will be expected at the time of service**. In the event your insurance provider issues payment to our office and your account is current, you will be issued a refund check.

Billing concerns or questions: If you have a billing concern or question, first review your Explanation of benefits (EOB) and contact your insurance company for more detailed information. Many times, this information is accessible to you on your insurance companies website/portal, and will be available to you prior to receiving a statement from our office. Second, if your concern or question continues please contact our billing office.

COPAYS:

All patients are required to pay their copay at the time of service, **NO EXCEPTIONS**. This is a requirement set by your insurance company and is contractual between them and us. It is a breach for us to waive or not collect the cop-pay. If you are not able to pay your copay at the time of service, we will gladly reschedule your appointment.

INSURANCE ELIGIBILITY:

With today's technology, we are able to verify insurance eligibility through our billing software and directly with the payers, prior to your appointment. **All patients must provider their insurance information (ID Card) to our receptionist at the time of every visit**. Bring your ID card and present **it at every visit**. If we are not able to verify eligible coverage, we may need to reschedule your appointment or charge you on a self- pay basis at the point and time of service.

NON-COVERED SERVICES:

Any procedures not paid for by your insurance carrier will require payment in full at the time of service. Any services denied by your insurance carrier are due within 30 days of notice of denial from your insurance carrier. We will attempt to bill you three times. If after this we have not received payment or established some form of payment plan approved by us, we will turn these balances over to collection and will not be able to provide services until any outstanding family balances are paid in full.

PERSONAL INJURY CASES:

Our office does not bill auto insurance carriers, other liability carriers or for any lawsuit related cases. Any services

provided must be paid for at the time of service. We do not accept liens. See our records policy for any requests related to medical information.

YEARLY WELL CHECK-UP:

Like most benefit plans, the Affordable Care Act, and as recommended by the American Academy of Pediatrics (AAP), our office requires that ALL patients have a yearly physical in order to evaluate the overall health and welfare of our patients. Failure to adhere to this policy may prevent necessary care, delay prescription refills and may result in dismissal from our practice.

PARENTAL ATTENDANCE/Consent:

Because you know your child best, we strongly encourage parental attendance at all visits. If married either parent may give consent. If you are separated, but not divorced, either parent may provide consent unless you present us with a court order to the contrary. In the case of a divorce, we request that you provide a copy of the divorce decree stating who is responsible for health care decisions and how access to records is handled. If shared parenting governs the decisions for your child's health care we will require a separate shared parenting agreement. We understand life is a busy place and this is not possible every time. Patients under the age of 18 **may be seen for sick visits** without a parent/guardian present. The parent/guardian will need to complete a **consent form** for the patient to be seen. The consent form is only good for one year and must be completed every year. It is best to do this at the beginning of the year so it isn't forgotten and therefore expired when you need it. See the "Forms" page on this website to download a consent form. (www.HealthOneOhio.com) **Patients under the age of 18 who are scheduled for a mental/ behavioral health visit or a routine well visit MUST have a parent /guardian present at the time of the appointment**.

Divorces and shared parenting plans can be congenial and truly in the best interest of the child (ren). It's this spirit of shared parenting that we encourage and want to participate in. All too often we see that the control and emotional issues take president to the child's best interest and the doctor's office is used as leverage and a sounding board, not generally in the best interest of the child. We appreciate the opportunity to become a part of your child's physical and mental well-being. If your are in a shared parenting arrangement **we will ask that both parents read and sign our Shared Parenting Agreement.** See the "Forms" page on our website to download this agreement (www.HealthOneOhio.com) or ask for a copy from the office.

APPOINTMENTS:

The patient experience is of the highest priority at Health One. All appointments are scheduled in an attempt to see everyone on time. We offer early morning walk-ins and same day sick appointments 5 and 6 days a week depending on the season. We are open generally from 7:30 am to 5:00pm 5 days a week, open until 6:00pm three days a week and open Saturdays 8:30am to 11:00am except during the summer months. After the 7:30am to 8:30am open walk-ins, the same day sick appointments must be scheduled after the phones turn on at 8:30am**. We also offer Tel-a-HealthOne telemedicine scheduled** appointments for ill, some well, follow up med checks and some refills for your convenience. To ensure your child is scheduled for sufficient time with a provider, please be sure to explain your child's symptoms in detail to the receptionist. Chronic or complex concerns may be scheduled for another day with your child's PCP. We make every effort to meet your scheduling request. We suggest that Well Child Checks & Medication Reviews be scheduled well in advance (see refills) so we can best accommodate each families scheduling preferences.

It's always important that you keep us informed of any changes to your demographic and insurance information. We place courtesy reminder calls for appointments as well as send reminders via our portal.

Late Appointments: A patient that arrives 10 or more minutes late for their scheduled appointment time may be asked to reschedule that appointment. If you are unable to arrive to your appointment on time, please notify our office as soon as possible. Please arrive 15 minutes early if there are any administrative things to take care of.

Missed Appointments: A patient that does not arrive for a scheduled appointment or fails to cancel the appointment 24 hours in advance is considered a "NO SHOW". We will send a courtesy notice to you advising you of the missed appointment. We understand that occasionally circumstances arise that may cause you to miss an appointment so we allow for one "oops" missed appointment. However, consistent missed appointments result in

wasted provider time, preventing others from scheduling who may need to be seen urgently. In our growing practice appointments can be limited, therefore; we ask Parents/Guardians to call at least 24 hours ahead to cancel a Well Visit, Medication Review, or New Patient appointment and at least 4 hours ahead to cancel an ill visit. **NOTE** DO NOT leave a message on the afterhours voice mail regarding the canceling of an appointment. (24 HOURS)

REFILLS: Maintenance medication that requires refills generally requires follow up visits every three months. Therefore it is **Mandatory** that you schedule a follow up visit on site at the conclusion of every visit. If this is not done and you call for a refill when running out of medication theres no guaranteed that we can get you in for the refill visit in a timely manner. The requirements and accountability on Doctors and providers has become much more stringent. Asking them to repeatedly refill without the follow up appointments literally puts their license in jeopardy. We cannot allow this to happen. Please be good Stuarts of medicine with us. Always schedule you next appointment while at the current one. Keep in mind this sometimes this can be accomplished with a Tel-A-Health One video appointment.

NO SHOW POLICY:

- **1st missed appointment**: A first notification letter is sent.
- **2nd missed appointment within a 1 year period:** a second notification letter is sent and a $45.00 charge is placed on your account
- **3rd missed appointment within a 1 year period:** A third notification letter is sent and a $85.00 charge is placed on your account. Dismissal from the practice is likely.

Charges assessed to your account due to missed appointments are not submitted or payable by your insurance company. Please keep in mind that our "NO SHOW" policy is a family policy; if accumulation of the children in your family exceeds our limits established herein, the dismissal typically applies to the family. Also note that any dismissal fees accumulated must be paid before any other appointments can be scheduled on a family basis.

ANNUAL MAINTENANCE OF PATIENT DEMOGRAHIC, INSURANCE, CONSENT AND COB INFORMATION.

Each calendar year

In an effort to keep records straight, appointments efficient with no delay of care we need the following information updated every calendar year.

1) Provide a copy of your Current ID card. (At each visit)
2) Update any Consent for treatment forms.
3) Update your Insurance Company with current Coordination of Benefits information (COB).
4) Be sure we have the current demographic information.
5) Please verify your pharmacy.
6) Pay any remaining balances.

It is best to update this information as early as possible for January 1 each year. If you wait until the first visit each year it may already be to late for some information like COB, consent, or insurance information.

PATIENTS FILING BANKRUPTCY:

Health One, Inc. reserves the right to discharge any patient and/or family which files bankruptcy listing Health One, Inc. as a debtor and results in financial adversity for the company.

AFTER HOURS CALL:

Our providers are here for you 24 hours a day, 7 days a week. If you have an urgent child concern, please call our office and you will be transferred to the "After Hours" voicemail to leave a message. One of our providers will return your call. Please do not leave messages for prescription refills, scheduling or canceling appointments, billing or other non-urgent questions on the voicemail. Our providers have been instructed to delete these calls. **The "After Hours" line is strictly for urgent health concerns. As always, if you deem your situation to be an emergency that cannot wait for a provider to return your call, you should call 9-1-1.**

COLLECTION POLICY:

We make every effort to contact and work with patients who have an outstanding balance prior to turning the account over to an outside collection agency. Once your account is turned over to collections, we will no longer treat your child and patient records must be transferred to another physician.

DISMISSAL CAUSES:

Although it's very rare and something we try to avoid at all costs, dismissing a patient from the practice becomes necessary when policies are not understood and respected or the communication between the parent/Legal Guardian has broken down.

Lying to the practice about anything from addresses, insurance, other care etc.

Involving the practice in domestic issues such as custody, shared parenting, consent or treatment needs

Treatment plan failure including annual well visit non-compliance

Distorting paper work

Drug Abuse or misused prescriptions

Outstanding Balances longer than 30 days after the insurance EOB has been produced by your insurance. Failure to make payment in a payment plan commitment.

Missing three appointments (No Shows) or being chronically late

Chronic abuse of the ER

Failure to comply with recommended treatment plans, Including Immunization refusal

Disruptive Behavior & Verbal Abuse: We understand we are in a position frequently where your stress level is high because you child is in distress or pain. Our team is trained to be as compassionate and helpful as possible but we cannot tolerate any verbal or physical abuse, or any behavior that puts our staff or patients in an awkward or dangerous position on the phone, in the waiting room, or in the treatment rooms. At any given time there are a variety of things going on and all patients deserve privacy and consideration.

SPONSORSHIP AND DONATIONS:

In order to not show favoritism amongst our patients, we do not sponsor or make donations to organizations upon request from our patients. We budget each year to give donations to specific charities and organizations.

SPECIAL FORMS & DOCUMENTS:

A charge of $30 will be assessed for completion of forms other than school sports physical forms or daycare immunization forms. The charge will apply to FLMA forms, disability forms, attorney/court forms, etc. Payment must be made prior to these forms being completed. Also see Medical Records.

MEDICAL RECORDS

A parent/Guardian or otherwise authorized requester must complete and Authorization to Release Medical Information form for any records beyond an Immunization Record. Records can be requested by the patient's parent (if a minor under the age of 18) or legal guardian, or, with patient authorization, by another physician or any person authorized by the patient. For copies of your child's medical records, we offer several options. For your convenience, a fee schedule based on Ohio Revised Code 3701.74 is available in our office as well as on our website.

- Records requested by another physician to be sent to a new Physician office are free of charge.
- **Immunization Records:** available free of charge. Immunization Records are available to you 24/7 via our Patient Portal which can be accessed from our website. We ask for 24 hours to complete your request in the office.
- **Complete Medical Records, Flash Drive:** $30 Flat fee per patient. Payment is due at the time of request & there is a ten 10 day processing time. We offer the option of getting records electronically because it is easily transferrable to another provider and allows you access to information as needed.
- **Complete Printed Medical Records:** per page fee schedule based on ORC 3701.741 (sample as of 2018) $2.74 cents per page for the first ten pages, Fifty-seven cents per page for pages eleven through fifty, Twenty-three cents per page for pages fifty-one and higher. Medical records can be extensive. These fees could easily exceed $75.00 or so. Payment of the final invoice will be required at the time they are picked up or before mailing.
- **Specific Information:** from a particular date of service or range of time will be subjected to the fee schedule based on the ORC 3701.741.

Under HIPAA a provider of care has 30 days to provide the patient or the patient's representative with a copy of the requested medical records; however, if the medical records are not maintained or are not accessible on-site, then a provider has 60 days to provide the records. A provider may extend the time for production once for an additional 30 days by providing the requester with a written statement of the reason(s) for the delay and the date by which the provider will produce the records.

Records Retention

If the patient is a minor on the date of the last visit, then Health one will maintain the pediatric patient's records for seven years from the date of the last patient encounter or until the patient reaches the age of eighteen, whichever is the longer retention period. If the patient is over 18 on the date of the last encounter, the adult records will be maintained for seven years from the date of the last patient encounter.

BY checking this box ☐ I certify that I **have read** and agree to the terms above and if applicable, the terms of the e-sign agreement & consent. I am also aware that if I have any questions regarding these terms that I have the ability to request that they be explained to me.

_____ _____

Signature, Parent or Legal Guardian Date

_____ _____

Print, Parent or Legal Guardian Date

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