Victoria Pediatrics and Adolescents Assoc., Felix F. Regueira, M.D.

4304 Retama Circle, Victoria, Texas. 77904, 361-576-2134

Office 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 each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Patient portal website https://health.eclinicalworks.com/VPAA

If you do not have the user/password, please ask front desk representative for the information. With patient portal, you will have access to: Appointments, Lab results, Medication, Medical Records, Education, Referrals, and send/receive Messages from staff.

Appointments

1. Patient/children are seen only by appointments. Walk-ins disrupt the flow of the practice, and we strongly discourage this. Walk-ins will only be seen if there are openings. Please call to set up an appointment and in most cases, we will be able to see your child for illnesses the same day.
2. We value the time we have set aside to see and treat your child. Broken appointments represent a cost to our practice and to you as well as other patients, who could have been seen during the appointment time set aside for your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $25.00 for missed appointments without 24-hour notice.**
3. If you are late for your appointment (>20 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
4. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
5. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
6. If your child is scheduled for a Well Check-up visit, that visit needs to be focused on child development, readiness or any other aspect of screening measures, etc. If your child is sick, dealing with chronic medical conditions, requesting blood work or further workup for a chronic disease it is at the provider's DISCRETION if your child can be seen for that additional complaint in the allotted time for a Well Check-up visit. If your child is seen for these other complaints, your insurance may be billed for TWO services at that preventive visit, which may cause lack of coverage and responsibility of payment by the financial guarantor. **PLEASE BE AWARE OF THIS SITUATION** and if possible, schedule a subsequent visit to be respectful of the provider's time and other patients who will be seen next. Thank you for your understanding in this matter.
7. Be prepared to present your insurance card(s) and driver's license, before or after your initial visit and periodically thereafter.

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Insurance Plans

1. It is your responsibility to keep us updated with your correct insurance information, as well as any patient information changes such as address, name and telephone number. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
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 yet been informed that we are your provider, **you may be financially responsible for your current visit.**
3. It is your responsibility to understand your benefit plan with regard to covered services and be responsible for non-covered services.
4. We accept a wide range of insurance plans. Our staff will assist you about our current insurance acceptance policy.
5. Self-pay patients will **NOT** be accepted.
6. Patients who have **Medicaid and private insurance** are required to declare to this office of insurance coverage from both. Failure to do so may result in **dismissal** from practice.

Initial_____

Financial Responsibility

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. It is our policy to collect co-payments when you arrive for your appointment.
2. Co-payments are due at the time of service. A $10.00 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 days of your bill.
4. If previous arrangements have not been made, any account balance outstanding longer than 28 days will be charged a $10.00 re-bill fee for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
5. Patient's with delinquent accounts will be discharged from the practice.
6. For scheduled appointments, prior balances must be paid prior to visit.
7. We accept cash, checks, MasterCard, Visa credit cards.
8. A $40.00 fee will be charged for any checks returned for insufficient funds.

Initial_____

Forms

1. Any school, camp, or sports forms are subject to a **$10.00** per form fee. Family and Medical Leave Act forms are **$30.00.** Payment is due when the forms are dropped off. We require 3-day turnaround time.

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Transfer of Records

1. If you transfer to another physician, we will provide a copy of your child's complete record including immunization record and your last visit to your physician, free of charge, as a courtesy to you with written consent. We need at least 10 business days to accomplish this.
2.

A copy of your child's complete record is available for a $25.00 for the first 20 pages, then $0.50/page thereafter, if you would like to pick up yourself. We need at least 10 business days to complete your record transfer.

Initial_____

Prescription Refills

1. If there are no refills left on your medication container, please do not call the pharmacy. Please, instead call our office. Please make sure all of your rescue/emergency medications have refills. Please **DO NOT** expect the on-call physician to refill these medications.
2. Antibiotics **WILL NOT** be called in to a pharmacy without the patient first being seen by one of our providers.
3. It is your responsibility to have one weeks' supply of your controlled substance prescription available.
4. Patients requiring controlled substance prescriptions will need to schedule check-ups every three months.

Initial_____

Dismissal from Practice

Your child may be discharged from our practice in the following situations (Our management reserves the right to make the final decision on this issue):

1. Failure to show up at your first appointment without proper 24 hr. notice given.
2. Multiple **"NO SHOWS"** (No 24 hour notice given); more than 3 "NO SHOWS" in a 12 month span.
3. Any rude behavior or use of profanity towards any of our staff members or our providers.
4. Any child who has been transferred to another provider, away from this practice by the parents/caregivers or has been dismissed from our practice, will **NOT BE ALLOWED TO RETURN TO VICTORIA PEDIATRICS AND ADOLESCENT ASSOC**., unless the transfer was due to moving out of town/state or insurance issues which could not be resolved by the parents, and our practice was properly notified before the transfer occurred. This policy will be applied to all siblings living in the household.
5. Failure to comply with treatment plan agreed upon by you and the provider (on more than one occasion).
6. Existing patient whose parent decides to **STOP** future mandatory vaccinations.

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Vaccinations

At this time, we are **NOT** accepting **and will dismiss** any new or present patient, respectively, whose parent(s) decide against vaccinating or modifying our schedule of vaccines. (Exceptions: Flu vaccines and HPV).

PLEASE NOTE: For patients transferring from another medical practice, your child will be accepted and given an appointment only after medical records have been received and reviewed by Dr. Regueira. Our office will contact you to schedule an appointment. If your child has seen a specialist, been prescribed medications for chronic conditions, required surgeries, or has been seen by another provider (for example: Urgent Care Clinic, Walk-in Clinic, E.R, etc.) please complete the necessary medical history questionnaire that our staff will provide prior to your visit or go to our website to print the form.

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

Patient Name(s):

_____

_____

_____

_____

Parent/Legal Guardian's Name_____

Signature_____Relationship_____

Date_____

On completion, we will provide you with a copy for your records.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and your child may be used and disclosed and how you can get access to this information. Please read it carefully.

Victoria Pediatrics and Adolescent Associates is committed to maintaining patient confidentiality while complying with all state and federal regulations in regards to protected health information. This policy was put in place as a result of the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA. The new laws were designed to protect and enhance rights of consumers by providing you with access to your health information and controlling the inappropriate use of that information.

STATEMENT OF USES AND DISCLOSURES

Protected Health Information, (PHI) is covered by state and federal laws. Therefore, the release of this information is carried out under strict guidelines. As a patient of this health care facility, a consent form is obtained for the release of medical information for the purpose of payment, treatment, and health care operations. This consent is obtained on the first date of service, and updated every year thereafter.

The disclosure of health information requires an authorization signed by the patient or representative for the following purposes. The authorization is revocable in writing 90 days from the date signed.

Examples;

- Life and Health Insurance Applications
- Selection of a new physician
- Release of Information to attorneys
- Release of Information to Patient/Legal Guardian

We may use or disclose identifiable health information without your authorization for the following purposes; public health reporting, auditing purposes, research studies, workers compensation and emergency care.

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STATEMENT OF INDIVIDUAL RIGHTS

Under HIPAA regulation patients have virtually unlimited access to their own health care information. Patient rights include:

- Consent to the use and disclosure of protected health information to carry out treatment, payment, or health care operations.
- Receive notice of privacy practices as part of the required consent form or process.
- Access protected health information.
- Receive an accounting of how their protected health information has been disclosed outside normal patient care channels.
- Agree or object to certain disclosures
- Request amendment or correction to protected health information
- Request restrictions on use of protected health information for treatment, payment, or health care operations.

Federal and State laws require VPAA to maintain the privacy of confidential information and to provide our patients with notice of legal duties and privacy practices. We are required to abide by this Notice currently in effect. We reserve the right to change the terms of this Notice and to provide our patients with the revised copy immediately.

Any concerns or questions regarding this Notice may be directed to the Office Administrator and VPAA at 361-576-2134.

By signing this form, I acknowledge that VPAA has provided me with a copy of their privacy policy,

_____ _____

Patient Name and D.O.B. Patient Name and D.O.B.

_____ _____

Patient Name and D.O.B. Patient Name and D.O.B.

_____ _____

Patient Name and D.O.B. Patient Name and D.O.B.

_____

Name/Date/Relationship to patient

Witness _____