ffrey K. Burton, MD, FAAP
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POLICY REGARDING LATE CANCELLATION OF APPOINTMENT and FAILURE TO SHOW FOR APPOINTMENT

Our office policy is to assess a charge for failure to cancel a scheduled appointment twenty-four (24) hours in advance. When an appointment is made but not kept or cancelled the time slot goes unfilled. The appointment time could have been given to another child needing to be seen during that time slot.

If we do not receive twenty-four (24) hours notice for cancellation of an appointment or fail to show for an appointment you will be assessed a charge based on the length of time set aside for that unused reserved appointment.

If the scheduled appointment is for a routine visit the charge will be $25.00, for a longer visit (i.e., physical, school physical, well baby check, consult, etc.) the charge will be $50.00.

You will be mailed a statement showing the charge for a late cancellation or failure to show appointment; payment is due on receipt.

When there are unusual circumstances we will make exceptions. The attending physician or Office Manager will approve these exceptions.

I have read and understand the cancellation/failure to show policy of All Children Pediatrics, PLLC.

____________________________________ _______________
Signature of Parent or Guardian Date

____
Name of Patient(s)

400 Blankenbaker Parkway, Suite 200 ✧ Louisville, KY 40243 ✧ (502) 244-6373 ✧ Fax (502) 244-9860

A NEWSLETTER TO OUR PATIENTS

WE WANT YOU TO KNOW THAT WE SINCERELY APPRECIATE THAT YOU CHOSE OUR MEDICAL OFFICE TO CARE FOR THE HEALTH OF YOUR CHILDREN. WE KNOW THERE ARE OTHER PEDIATRICIANS THAT ARE AVAILABLE IN LOUISVILLE, SO BE ASURED WE WILL TRY OUR BEST TO PROVIDE THE SERVICE YOU AND YOUR CHILD(REN) DESERVE.

FEDERAL AND STATE LAWS AND HEALTH INSURANCE CONTRACTS PRECLUDE US FROM DOING SOME THINGS THAT WE BELIEVE ARE IN THE BEST INTEREST OF THE PATIENT. WE SERIOUSLY TRY TO ADDRESS THESE REGULATIONS AND STILL GIVE YOU THE ATTENTION AND INFORMATION YOU NEED TO MAKE INFORMED DECISIONS CONCERNING NOT ONLY THE PHYSICAL NEEDS OF YOUR CHILD(REN), BUT ALSO ADDRESS YOUR FINANCIAL NEEDS! THE INFORMATION LISTED BELOW IS DUE SOLELY BECAUSE OF THIRD PARTY AGENCIES. WE APOLOGIZE FOR ANY INCONVENIENCE CAUSED TO YOU.

1. *If your child is here for a sick visit, we cannot give an immunization during this visit.*

2. ***For laboratory services** you are free to go to an outside laboratory that is approved by your insurance carrier, or have your lab done in our office. We do charge a fee to cover the costs of the lab supplies and staff. Your insurance may or may not pay this fee, and thus, this fee would be your responsibility.*

   ***For X-ray,** we do not have access to x-ray equipment in our office; thus you will be expected to have x-rays completed at the facility approved by your insurance carrier.*

3. ***Payment** is expected at the time of service for all co-pays, co-insurance, deductibles and for services not covered by your insurance. If you have no insurance coverage you are expected to pay each visit in full.*

4. ***All unpaid insurance accounts** will be transferred to "patient responsibility" after 90 days. We will do everything we can to assist in processing your insurance, but the final responsibility for payment is yours.*

We strongly urge you to review your insurance contract or talk with your contract representative. There are numerous insurance plans, and we cannot be responsible for information available in each plan.

You can be sure that we will be pleased to talk with you and direct you in any way that we can. Our Billing Representatives can be reached at 502-244-6373.

I have read the above information and do realize that any charge not approved by my insurance plan is my responsibility.

____________________	____________________	________
Guarantor Signature	Guarantor Printed Name	Date

____________________	____________________
Patient Name	Guarantor relationship to patient