Children First 17618 Main Street, Dumfries VA 22026 703-441-8998 Fax 703-445-8568 Childrenfirstdumfries.com

WITH YOUR INITIALS, PLEASE INDICATE THAT YOU HAVE READ UNDERSTAND EACH POLICY.

_________**Office Visits:** are by appointments only. Walk-ins are seen on the next available appointment just as if they had called. Medical emergencies are encouraged to go to the ER, especially if a fracture is suspected so that x-rays can be taken by the hospital.

_________ **Late arrival policy**: patients are asked to arrive 10 minutes before their appointments time in order to complete their check in process. Patients arriving more than 15 minutes late will be re-scheduled to the next available opening depending on the type of appointment requested. Acute ill patients will be fit in the schedule later the same day.

Immunization record: If your child is new to our practice, you must provide us with a copy of his/her immunization so that we can continue providing proper and accurate immunization schedule.

__________ **Appointment cancellation policy**: As a courtesy, we will give you a reminder call two days before your next appointment with our office. Ultimately, it is your responsibility to keep your own appointment. As a courtesy to the doctor and to other sick children, we require that you cancel any scheduled appointment 24 hours in advanced so that other families can utilize this time. Missing any appointment without prior cancellation is considered NO SHOW NO CALL. The office allowed one NO SHOW NO CALL per family without charging. Effective March 1st, 2015, this office will charge $25.00 for a SECOND NO SHOW NO CALL. If a family or child accumulate a THIRD NO SHOW, Children First, Inc will be forced to report you to your insurance and to dismiss your family from the practice.

_________ **Co-pays & co-insurances**: Must be paid at the time you are checked in, on each visit. This is an agreement with your insurance company.

_________ **Children under 18 years**: Must have a parent or legal guardian present. Legally, they cannot consent to their own treatment. If you are unable to attend to their appointment and must send your child alone or with an older sibling, such as grandparent or nanny, please be advised that they do not have legal authority to provide consent to treat your child. You must send a SIGNED LETTER OF AUTHORIZATION WITH THEM or give us written pre-authorization indicating the name of the person who is authorized to bring your child. You can request a PRE-AUTHORIZATION form from our front desk.

________**Insurance IDs & coverage**: If you would like us to bill your insurance company for your child(ren)care, you must present a valid and active insurance ID. IF YOUR CHILD IS COVERED BY TWO INSURANCES, you must provide us with both insurance ID and policy holder information. Failure to present both insurances, will result in claim rejection or payment retraction from primary insurance, making you responsible for the entire balance. If you have an HMO or MC policy, you are responsible for selecting Dr. Indira Sinha as you child PCP, (primary care provider) before services are render or assume full account $ balance respnsibility.

________**Account balances**: Any account balance not paid within 60 days from date of your first statement, will be transferred to TransWorld Systems, for full collection and $25.00 collection fee will be imposed to your account, plus $1.20 interest. In addition, you will be required to provide us with a credit card to be kept on file in case you fail to keep you account current .

________ **Bad/ demanding attitude**: Children First, Inc. reserves the right to refuse service to anyone who poses a threat to this office or staff, or anyone who do not comply with our policies.

_______**Form fees**: We charge $5.00 to $10.00 to complete forms and takes up to 48 hours to complete them.

_______ **Medical record fees**: We charge $15.00 processing fee + $0.25 per page. A copy of the immunization record can be printed at no charge. By activating a web portal account, you may access your child's medical information, and print your own copy at no charge. Ask any staff for more detail.

Patient's name ____ DOB _________________________

Patient's name: ____DOB _________________________

Patient's name____ DOB _________________________

Patient's name ____DOB _________________________

Parent's name _________________________________ Signature ________________________ Date: _____________