Office Policies

Clinton Preferred Pediatrics is committed to providing the best quality care for your child/children. We promise to give you our full attention at each and every office visit. We strive to schedule and examine your sick child on the same day of illness that you call us. If your child is scheduled for a well exam (physical or "check up") we encourage you to arrive 15 minutes early to the appointment to have time to complete all appropriate questionnaires and have our medical assistants perform other necessary wellness checks.

We are not a walk-in clinic. We ask you to call and schedule all appointments, including vaccine-only appointments. This will ensure our office staff is prepared and ready for your child.

Our doctors see patients between 9:00am thru 5:00 pm Monday thru Friday, and 8:30 am thru 12:00 pm on Saturday. We begin answering phone calls at 8:00 am every morning of office hours. We will schedule later appointments on Monday, Tuesday, and Thursday evenings, as needed. Unless cancelled, our policy is to charge for missed appointments at the rate of a normal office visit.

We encourage you to call during office hours for any questions and concerns. If an urgent matter arises when the office is closed one of our doctors is available by phone. You may reach the doctor on call by calling our answering service telephone number: 248-544-6906. We appreciate that our patients recognize that our doctors have families of their own, and thank you for only calling after hours with urgent matters that cannot wait until the next business day. The doctor on-call will not have access to your child's chart, so please do not call for medication refills after hours.

Financial Policies

We are in the midst of an ever-changing health care enviroment. Insurance policies and contracts have become very complicated and we need your help in order to assist you in receiving your maximum allowable benefits. We appreciate you inquiring, and expect you to know, if your policy covers well exams (physicals, preventive visits, "check ups") and vaccine and lab tests done in the office. (urinalysis, hemoglobin, rapid strep screens, etc.). You should be aware of any deductibles you have (an amount that you must pay before the insurance company begins to pay) and the term it encompasses. You should also know if your policy requires referrals to see specialists and if those specialists we recommend are "in-network" or "out of network". It is your responsibility to ensure that we have your current insurance card on file. Copays, set by your insurance policy, are due at the time that service is rendered. Payment is the responsibility of the patient's parent or guardian and the adult accompanying a minor for treatment. We will bill your insurance company after each office visit. Your insurance company will then reconcile charges with our office billing. Any balance remaining on your account for services not fully covered by your insurance company is your responsibility and you will be billed for that amount. We appreciate payment upon receipt. We accept cash, checks, Visa, Mastercard, and Discover. If paying by check non-sufficient funds are a charge of $25.00 and will be billed to you. Your account will be transferred to a collection agency if you do not pay your outstanding balance after receiving three billing statements. This may also result in a notice indicating that further medical care in this office will be discontinued. We realize financial difficulties may occasionally arise and we ask that you contact our billing department promptly in that situation.

Our Phone System

In order to serve you efficiently we would like to explain our phone system.

Our daytime message is as follows:
Thank you for calling Clinton Preferred Pediatrics. Our office is open. You have reached our voice mail system. **If this is an emergency, please hang up and call 911.**
Between the hours of 12:30 and 1:30 the doctors are at lunch.
Please listen carefully to the following options:
If you are calling from a hospital or physician's office, or need immediate attention, please press **1**.
To speak with our medical assistant regarding medical questions that are not emergent related or for refills on medications, please press **2.**
If you are calling to schedule an appointment with Dr. Sobocinski, please press **3**.
If you are calling to schedule an appointment with Dr. Buzenski or Dr. Schweighofer, please press **4**.
If you need test results, please press **5**.
If you need an insurance referral, please press **6**.
For billing assistance, please press **7**.
Our address is 15500 19 Mile Road, Suite 300, Clinton Twp., MI 48038 and our fax # is 586-263-8491.

Patient Legal Name: _____ DOB: _____

Pharmacy:

For your convienence and safety, we have a computerized prescription program that will improve both the accuracy and convienence of prescribing medications. This will allow for the electronic transmission of most of your prescriptions directly to your pharmacy and may help eliminate your waiting time. To implement, we need to collect some information on your pharmacies of choice.

Main Pharmacy:
Name: (CVS, Rite-Aid,etc.) _____ Address: _____
City, State, Zip: _____
Phone #: _____

Alternate Pharmacy:
Name: _____ Address: _____
City, State, Zip: _____
Phone#: _____

To coordinate pharmacy with other family members, please list sibling's names and date of birth:

Name:	DOB:
_____	_____
_____	_____
_____	_____
_____	_____

Consent To Treat: I authorize and consent to the treatment deemed necessary by the physician/physician's assistant for my child, which may include assessment of health status/history, first aid, necessary minor procedures, physical examination, health education, referral and follow-up. I authorize and consent to the use or disclosure of my child's protected health information (PHI), including demographic information, made available in the notice of Privacy Practices that is posted in a clear and prominent locationwhere I am able to read the notice. I authorize Clinton Preferred Pediatrics to fax, phone and e-mail any of my child's protected health information that will be used only for treatment, payment, or other healthcare operations. I authorize that my child's protected health information may be included on a school health form, a return to school or work form, and I give my consent to this Practice to mail a yearly check-up reminder card to my home. I also authorize the following people to receive my child's protected health information (PHI). Please check one or more of the following: __ grandparents ___ babysitter __siblings __parents __ other __ I do not authorize anyone else

Release of Information for Payment: I authorize the release of any medical or financial information, including protected health information, identifying information and any information related to AIDS, AIDS Related Complex (ARC) or HIV and any information regarding substance abuse treatment protected by 42 Code of Federal Regulation (CFR), part 2, and any mental health treatment, to any third party reponsible for paying all or part of my child's medical bill. I understand that this authorization to release information may be revoked at any time and is only for the purpose of obtaining payment.

No Guarantee of Results of Care and Centers Termination Rights: I agree no one has promised or guaranteed any results of my child's medical care. I agree that nothing in this form prevents the Medical Center and its staff from terminating my child's care if I am given reasonable notice and a chance to obtain medical services elsewhere.

I have received the office and financial policies. I acknowledge the Notice of Privacy Practices. I realize my responsibility as I now belong to a Patient-Centered Medical Home. I authorize all insurance benefits to be paid directly to Clinton Preferred Pediatrics. I will review all information given to me and know that I can also read this online at www.clintonpediatrics.com.

Name of Parent/Guardian : _____

Signature of Parent/Guardian: _____ Date: _____