LINDA PERRIN, RN, CLC, CPNP and KELLY ELLISON, RN, CFNP
811 IRA E. WOODS AVE
GRAPEVINE, TX 76051
(817) 481-3585 website: www.practicalpeds.com

Office Hours
Monday - Friday 8:00am - 12:30pm & 2:00pm - 5:00pm
Telephone Hours
Monday - Friday 8:00am - 12:30pm & 2:00pm – 5:00pm

Nurse Calls
A nurse is available during regular business hours to answer any questions and give advice. Nurse calls are returned in the order they are left and by the nature of the call. All calls left before 4:30 will be returned the same day. In case of emergency please dial 911. For after hour emergencies please call the main number for further instructions.
Initial: _____

Prescriptions
When calling for a refill on an existing prescription, please contact your pharmacy and they will contact our office. Controlled prescriptions must be requested 24 hours prior to pick up. There will be a $**5.00 fee** for same day pick up and a **$5.00 fee** sent by mail, please note the mailed prescription cannot be replaced without returning the original prescription to the office. All medication forms for school/daycare there will be a **$5.00** fee to complete.
Ini**tial: _____**

Appointments All Office Visits are by appointment only
Nurse visits, such as weight checks, and immunization updates must have scheduled appointments. It is recommended to make all Well Child appointments 2 months prior to needing appointment. School physicals are scheduled in the summer months and are filled quickly, please call ahead. **If you are unable to keep your appointment, please call our office 24 hours prior to appointment time. Failure to cancel a Well Child and/or ADHD follow up appointment will result in a $25.00 fee. Failure to cancel a Consult or ADHD Evaluation will result in a $50.00 fee**. If you are late for your appointment (>15 minutes) we will do our best to accommodate you. However, it may be necessary to reschedule your appointment.
Initial: _____

Forms
Our office will complete any school physical forms at the time of appointment. A request for forms to be completed other than at your appointment requires a 24-hour turn around and a fee of **$10** per form payable upon request. A copy of your child's shot record will be given at each Well Exam. If an additional copy is needed, there will be a **$5.00 fee** for each request. Family and Leave Act forms are **$10.00**. All forms that require a physician signature only there will be **$5.00 fee** per form. Patient portion of the forms must be completed by the parent/ patient before the physician can complete his/her portion.
I**nitial: _____**

Financial Policy
All patients must bring a valid insurance card and be prepared to pay all patient portions (co-pay, deductibles) at the time of service. If your plan requires a deductible to be met, we will collect an estimated amount at each appointment and a statement will be mailed for any remaining balance due. If our office is unable to verify coverage for your child, please be aware you will be responsible for the full payment at the time of service. It is your responsibility to notify the office staff of any changes in your insurance, address and/or phone numbers. Our office will file your primary insurance only for you, we do not accept secondary insurance. If payment is not received by your insurance within 45 days, it will become your responsibility to pay the outstanding balance. We charge a **$30.00 fee** for all returned checks. Payment of all returned checks and all future payments will need to be paid by cash or credit card.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
I authorize the release of any medical information required to process claims. I also authorize payment of medical benefits to the provider of benefits. I understand this office does not accept Medicaid or the fee for Medicaid patients.
Initial: _____

Referrals
Should you require a referral to a specialist, please allow 4 business days for all non-emergent referrals. It is your responsibility to know if your specialist is a participating provider. Referrals must be approved by the provider before they are issued.
Initial: _____

Copy or Transfer Medical Records
If you want a copy of your child's records, or want us to send your child's records to a different provider, please request and complete our Authorization to Release Medical Records Form. There is a **$25.00 fee** per patient for medical records that must be paid upon request. Please note the balance on the account must be paid before records will be transferred. We provide records of your child's visits rendered here at Practical Pediatrics and consultations from specialist while under our care. For any other medical records you will need to request them directly from your previous provider(s).
Initial: _____

I have read the above information and understand the policies and procedures of Practical Pediatrics.

Date: _____ Patient Name: _____ DOB: _____

Signature: _____ Relation to Patient: _____