Bloom Pediatrics
Where Good Health Grows

2055 E 14 Mile Road
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bloompediatricsmi.com

Thank you for choosing Bloom Pediatrics for your medical care.
Please review our policies and procedures below and sign where indicated.

PATIENT NAME:_____

- Patients must arrive 15 minutes before their scheduled appointment time and provide their insurance card, photo ID and insurance copay if applicable at check-in. We have a contractual obligation to your insurance company to collect copays at time of service.
- A no-show or late cancellation fee of $50 will be charged to patients who do not provide 24 hour notification to cancel an appointment or for patients who miss their appointment. After 3 no shows or late cancelled appointments you may be discharged from the practice.
- If you arrive 15 or more minutes late to your appointment you may be asked to reschedule.
- Copays not paid at time of service will be assessed a $15.00 fee.
- **If your child is being seen for a Well Child Check and you have other concerns that are not related to routine, wellness care, those concerns may generate other charges to your insurance.**
- Any outstanding balances due to deductibles, co-payments, and services not covered by your insurance are your responsibility. All balances must be paid promptly. If you are unable to pay the balance in full please contact our billing department to make payment arrangements. Non-payment of charges will result in the account being turned over to a collections agency and your family will be discharged from the practice.
- Our phones are open 7:00am-8:00pm Monday-Thursday, 7:00am-5:00pm on Friday and 8:30am-1:00pm on Saturday. After hours, we offer a telephone triage consultation service that puts you in touch with a pediatric-trained triage nurse via our answering service.
- Please allow 3 business days for all forms and prescription refill requests.
- Bloom Pediatrics will use and disclose health information about the patient in compliance with the HIPAA Act. You are entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. You have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. Bloom Pediatrics is not required by law to agree to such requests. Your signature below acknowledges that you are aware of your rights in accordance to HIPAA.
- We keep a record of the health care services we provide your child. You may ask us to see and copy that record (copy charges may apply). You may also ask us to correct that record. We will not disclose your child's record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Contact the Record's Custodian to see the record or to get more information about it.

I,_____,the parent or legal guardian of_____ authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

I acknowledge with my signature that I have received a copy of the full financial and practice policies (summarized above). I understand the policies and will comply.

_____ _____

Parent/Guardian/Patient Signature Date