NAOMI SATO, M.D., F.A.A.P. • *PEDIATRICS* • ROBYN L. KIMURA, M.D., F.A.A.P.
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No Show Policy (updated 6/1/2017)

Our office allows no more than four (4) failed appointments ("no shows") per family within a 12 month period. Failed appointments include well visits canceled/rescheduled less than 24 hours prior to appointment time, ill visits canceled/rescheduled less than 1 hour prior to appointment time, and any visit where the patient arrives 15 minutes or more after appointment time. A verbal warning will be given on the first, second, and third failed appointments and documented in the patient's chart. On the fourth failed appointment, a certified letter will be sent to the parent, guardian, or patient stating that the patient has one month to find another physician. It is our policy to discharge at the same time all siblings in a family with four no shows. During this three week period, our office will continue to provide care if the patient becomes ill.

To prevent an appointment from being marked as failed, **please call our office to cancel or reschedule your appointment 24 hours BEFORE the scheduled appointment time. Failure to cancel or reschedule a well exam appointment at least 24 hours in advance will result in a charge of $25.00. This fee is not billable to insurance and is the patient's responsibility to pay.**

_____ (initial) I understand this policy about failed appointments.

Notice of Privacy Practices Acknowledgement and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assurance and physician certifications.

This office's *Notice of Privacy Practices* describes the uses and disclosures of my child's health information. I understand that I may request in writing that the office restrict how my child's private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

_____ (initial) I have received, read, and understand this office's *Notice of Privacy Practices*.

_____ (initial) I consent to the use of my child's protected health information as described in this office's *Notice of Privacy Practices*.

Responsibility for Payment

Insurance policies are an arrangement between the carrier and the patient and are designed to offset a portion of the total cost of care. **In order to process claims efficiently, you must provide us with current and accurate information.** This office will prepare any necessary reports or forms, using the information provided by you, to assist in making collections from insurance companies directly to the patient or to this office as credit to the patient's account. For services or treatments denied or not covered by the patient's insurance, the parent/guardian is responsible for the bill.

_____ (initial) **I understand that I am ultimately responsible for the bill, regardless of insurance coverage.**

_____
Patient Name

_____
Parent/Guardian Name (Print) Relationship to patient

_____
Parent/Guardian Signature Date