



**SILVERDALE PEDIATRICS**  
**OFFICE POLICIES AND PROCEDURES**

Welcome and thank you for choosing Silverdale Pediatrics. We are grateful for the opportunity to provide you with the highest level of preventative, diagnostic, therapeutic care, including medication management. This contract governs the way Dr. Niran Al-Agba and Dr. Joy Ziemann and Silverdale Pediatrics (“the practice”) operate. This document is lengthy because it has Silverdale Pediatrics entire Office Policies and Procedures, which includes the communication information, after hours care, a financial agreement and other important material. Please take your time to review and fully understand this document. This document can also be viewed at [www.silverdalepediatrics.com](http://www.silverdalepediatrics.com).

**OFFICE HOURS AND APPOINTMENTS:** Business Hours: Silverdale Pediatrics business hours are Monday through Friday from 9:00am until 2 pm. Dr. Niran Al-Agba’s hours begin and 9:00am until 12:30pm and is generally off on Thursdays. Dr. Joy Ziemann is typically in the office on Thursdays from 9:00am until 12:30pm Our hours are subject to change due to doctors other medical and personal obligations and we will post these changes whenever possible at Silverdale Pediatrics Facebook page and website. We will only on rare occasions make an exception to see a patient outside these hours.

Appointments: When you schedule an appointment it guarantees you time with the doctor. It does not guarantee any specific medications, treatments or letters. We believe a therapeutic relationship is formed over time where the diagnosis is refined and treatment approaches are optimized. We hope to build a lifelong relationship with you and your family.

Unattended Children: Our office request you do not leave your (small) children unattended at any time in the waiting area. We are not responsible for unattended children in the waiting area. We truly apologize for any inconvenience this may cause. If you have any questions please ask our staff.

No-Shows/Late Cancellations: We value your time, and we hope you value ours. We never double book patients, and we aim to give patients very personal and uninterrupted care. To better serve our patients we created a late cancellation/no-show policy. This helps our community and others suffering with any medical reason needing our attention who could have otherwise been seen for urgent appointments. Therefore, patients who do not give a notice of cancellation (“no-show”) or cancel with less than 24 hours of notice, (“late cancel”) can be charged a fee. In the same spirit patients that are more than 15 minutes late to the scheduled appointment time can also be considered a no-show and could be rescheduled.

Calls/Texts/Emails: As a courtesy we provide an appointment reminder service via text, email or voice call with an option to confirm the appointment, cancel or reschedule. This service is a courtesy. It is the sole responsibility of the patient to manage acquired appointments. Stating that you did not receive a courtesy reminder does not exempt you from being assessed a missed/late



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cancellation fee should this happen. We don't rush our patients and we hope you wouldn't want your doctor to be rushing in making a decision that could affect you or your children in significant ways. We also understand our patient's hectic schedules and extenuating circumstances, for this reason we will extend a level of flexibility when making these decisions on a case by case basis. For the fee amounts, see our financial agreement below.

**Office Closure:** If an emergency arises that cannot wait, please call 911, a crisis hotline or go to your local urgent care or emergency room. In the case of inclement weather, the office will at times be closed if the public school districts are closed. Please check our Facebook page for updated information or call our office. Our office staff will also attempt to notify you about the closing of the office and every attempt will be made to reschedule you at your first convenience. Our typical holiday closures will also be posted to our Facebook page and or our website.

**FINANCIAL AGREEMENT:**

- **CREDIT CARD:** To book an appointment with our doctors you are asked to provide us with a credit card number which we leave on file.
- **Billing:** Once a claim has been paid and we enter payment, if there are additional charges that have been deemed patient responsibility, we will issue a bill. On the bill it will say when your card will be charged (typically two weeks later). The card on file will automatically be charged on the day written on your bill. If you would prefer to set up a payment plan, please call our office to make the proper arrangements. We are happy to accommodate you!
- **Insurance:** Silverdale Pediatrics participates with most commercial insurances, including Medicaid (Molina only) to offer patients treatment, pending verification of benefits. If there is a change in the insurance plan, please notify our office immediately. All **copays** are expected at the time of service. If the copay is not paid at the time of the visit a \$25 administrative fee will be assessed to the patient for each copay. The fee must be paid prior to being scheduled for the next visit.
- **Account Balances:** A deposit is required for new patients and patients with high deductible plans until the insurance plan begins to pay for the visits. Deposits will be refunded for the visits once the insurance begins payments. Any difference in the balance owed will be charged to the patient or refunded accordingly. If payment for 3 or more visits are outstanding, patients are then expected to pay for care directly. The payment will be refunded accordingly if subsequently paid by the insurance company. The credit card provided on file will be used to pay these balances but not without prior notice to the patient. Additionally, payment plans are also an option provided to patients on a case by case basis.
- **Fees:** in the case of a no-show/late cancellation of a new patient appointment the fee is \$150 (one hour visit), and you will be asked to find another physician. All other no-show/late cancellation fees will be \$50.00. These fees are not covered by your

  
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insurance companies, and are the personal responsibility of the patient. These fees apply to all patients even if they do not have insurance. Prior authorizations are a time consuming process and levied by your insurance company. We charge \$25.00 per prior authorization to cover staff time to complete the process. This is not covered by your insurance and is the patient's sole responsibility.

- Walk-in Visits: If a patient comes into the office without an appointment, a \$70 non-billable fee will be charged if the patient is seen. To avoid this fee, please be sure to call our office to make an appointment in advance.
- Phone visits: For after hours calls to the Seattle Children's nurse triage, there will be a \$40.00 charge. There is a \$50.00 fee for a 15 minute phone consultation with one of our physicians, this requires an appointment and payment in advance.
- Insurance billing: We bill your insurance as a courtesy; it is your responsibility to inform us of changes to your coverage. If we are not informed there is a \$35 administrative charge per claim. We follow your insurance company policy for copays, deductibles and patient responsibility.
- Forms of payment: We accept cash, personal checks and most credit cards. All returned checks will be assessed a \$50.00 which is the sole responsibility of the patient. All no-show/late cancellation and returned check fees must be paid prior to scheduling another appointment. Your credit card is used to secure payment in the case that there are unpaid balances for these charges for over 30 days.
- Termination from the Practice: No-show or late cancellation appointments or an inability to meet patient financial obligations may result in termination from the practice. If you believe that there are extenuating circumstances, please talk to the practice manager.
- Uninsured patients: If you do not have insurance, payment in full is due at the time of service. Base rates are: for a sick visit is \$125.00, for Well checks are \$175.00, and med checks \$200.00. These are base rates, if additional care is required or necessary please consult the physician at the time of visit as additional charges may apply.
- Office closure: We regretfully have to close the practice from time to time for various reasons for holidays, professional or personal reasons. We will post the office closures on Facebook or our web site in advance whenever possible.

**POLICY ON NON-COVERED SERVICES:** Some services are not paid by insurance companies, but patients or their representatives may occasionally request the physician to perform them and or to coordinate care with other organizations to offer a consistent and quality care on your behalf. However, these services may take up a significant amount of the physician's time. Because of this the following services are billed at an hourly rate of \$300.00 an hour.

Examples include;

- Preparing reports or letters for other providers or organizations
- Completing documents for disability claims, insurance reviews or workers compensation



- Evaluation, testing or treatment services not covered by insurance.

Court ordered and legal related services, including assessments, preparing for depositions, travel time, court time, and writing reports are considered forensic-type services and are billed at a higher rate, (half and full day increments). For more detailed information please speak to a manager directly.

#### **ELECTRONIC COMMUNICATIONS:**

Our preferred form of communication is in person or over the phone. We do not offer any secure electronic means of communications for HIPAA compliant information. We also strongly discourage any communication over our email service, social media or web site involving your medical care or needs. We cannot guarantee your privacy.

#### **CONSUMER ETIQUETTE:**

Disrespectful, abusive behavior or harassment towards the doctors or office staff will not be tolerated. If this occurs it is grounds for termination from our practice.

**GRIEVANCES:** Our practice values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. If the staff at Silverdale Pediatrics have fallen short of this goal, we want you to notify us. Please be assured that your complaint will be kept confidential. Please contact one of our managers, Mr. Lawrence Green, who will attempt to resolve your concern in a professional and swift manner.

#### **ACCOLADES:**

Our practice values you as a person and we hope that we treat each person with dignity and respect. If you feel we went above and beyond, we would love to know and hope you can share this with others.

**PRIMARY CARE:** We care about your overall health, and therefore all patients should be under the routine care of a primary care physician.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We generally update all our forms once per year. The most current version of the consent form that was made while I am a patient will effectively govern our relationship. This agreement shall not be declared void or ineffective by virtue or nay state or federal statute or regulation, or decision of any court or regulatory authority, such declaration shall not invalidate any of the provisions of this agreement that otherwise remain in full force and effect.



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**PATIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT OF OFFICE POLICIES AND FINANCIAL CONSENT**

I, \_\_\_\_\_, understand that Silverdale Pediatrics LLP does insurance verifications as a *courtesy* for their patients. By signing this form, I am acknowledging that I have read and understood this Policy and Financial Guide. I understand that the benefits quoted are not a guarantee of payment by my insurance company and that my health insurance company(s) will receive claims for service from my physician.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

NOTE: Attach to Insurance/Patient Payment counseling & informed financial consent form.