WP
Wayland Pediatrics

Drs. Ellen Mahoney and Maya Dor along with Nurse Practitioner Nancy Crowley, welcome you to Wayland Pediatrics. This packet of information is to help familiarize you with our office and some of its policies. Hopefully, it will allow your transition to occur as efficiently as possible. As soon as we receive the requested materials we can enter your family into our data base and be prepared for your first visit.

Please visit our website at www.waylandpediatrics.com for more details and directions to the office.

Below is a list of the items we will need from you to start the registration process.

Check list:

1. Demographic sheet
2. Signed HIPPA statement
3. Signed financial statement
4. Copy of immunizations or reproduction of Mass Blue Book
5. Record release for previous physician
6. Copy of both sides of medical insurance card

Thank you,

Christy Macary

Christy Macary, Office Manager

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Wayland Pediatrics

73 Pelham Island Road * Wayland, MA 01778

Home/Mailing Address:_____

_____

Home Phone:_____ **Cell Phone:**_____

1st Parent's Name: _____ **Date of Birth:**_____

Email:_____

Work Phone:_____

Employer Name_____

Employer Address:_____

2nd Parent's Name:_____ **Date of Birth:**_____

Email:_____

Work Phone:_____

Employer Name_____

Employer Address:_____

Children's Names: **Date of Birth:**

_____

_____

_____

_____

Preferred Pharmacy:_____ **Town:**_____

Preferred Provider: Dr. Maya Dor Dr. Ellen Mahoney Nancy Crowley, cPNP

Physician listed on insurance policy (if required): Dr. Ellen Mahoney Dr. Maya Dor

Insurance Company: _____

Address: _____

Member ID#: _____

Guarantor's Name: _____Date of Birth: _____ SS#:____-____-____

I hereby authorize payment for medical treatment by Wayland Pediatrics, L.L.C.I also authorize Wayland Pediatrics to release information as required by other physicians and insurance carriers. Signature of Parent/Guardian:

X_____ please sign here

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Ellen Mahoney, MD Maya Dor, DO Nancy Crowley, cPNP

Financial Policy.

Wayland Pediatrics acknowledges that it is a privilege to provide medical care to your family. We would like to give the best care at a reasonable fee. In order to hold billing costs to a minimum we expect payment at the time services are rendered, unless prior arrangements have been made. In order to be able to continue to see our patients in a timely manner for urgent issues we will charge a $25 fee for appointments which are not cancelled 24 hours in advance.

As per *your* contract with your insurance company, at the time of service you are to:

1. Present your child's insurance card.

2. Be prepared to pay your co-payment/co-insurance as stipulated in your contract (found on the face of your insurance card). In most cases, no co-pay will be collected for preventative services. However, if additional issues are addressed during the visit, a copay will be required (please see posted policy on this issue)

3. Inform the office of any insurance, billing or contact (telephone and address) changes.

4. Be prepared to pay any deductible as stipulated in your contract with your insurance company. (Often the insurance company has a website for this purpose). We are unable to do this for you since we are not privy to this information so please review this information prior to your visit.

For your convenience we will accept Mastercard, Visa, checks or cash. If your check is returned for non-sufficient funds, the bank will debit your account for the amount of the check, plus any applicable fees and we will bill you a $30.00 service charge. The use of a check for payment is your acknowledgement of this policy.

If someone other than a parent brings your child for care, they must provide the above information and pay the appropriate charges on your behalf.

If we must bill you, a $10.00 service charge will be added to your balance. The balance is due within 21 days. We recognize that extenuating circumstances may exist that will warrant special payment consideration. Please contact A-Stat Medical Billing (401)723-5533 with any questions regarding your bill.

_____

Signed/Date

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Acknowledgement and consent form

Patient name:_____

I have reviewed a copy of the Notice of Privacy Policy. In connection with the medical services that I am receiving from the above-named physician, I hereby authorize the disclosure of any or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

Any third-party payor covering medical services of the patient

Other healthcare professionals and institutions involved in the delivery of healthcare to the patient

The proponent of any legally sufficient subpoena, or in response to a court order

Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services

Pharmacies

Other parties as otherwise required by law

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

This consent is valid from the date executed, until revoked in writing by myself.

Signature_____Date_____

Printed Name_____

Appointment Policy

Dear Patients and patient families,

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

1. **Cancellation/No Show Policy for Doc Appointments**

In Order to be respectful of the medical needs of other patients, pleas be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

If an appointment is not cancelled with proper notice you maybe be charged a fee: your insurance company will not cover this charge. Insurance companies only consider covering costs when services were actually rendered.

Fee Schedule

- First missed appointment: No charge. We understand that mistakes happen
- Second missed appointment: $25 fee will be billed to your account
- Third missed appointment: $50 fee will be billed to your account

Repeated no shows may result in the patient and/or family being discharged from our practice

Fees are the discretion of our business manager

Fees are incurred for each child scheduled Example: 2 siblings scheduled=2 fees

2. **Late Arrivals**

We understand that delays can occasionally happen; however, we must try our best to keep the doctors on schedule. If a patient arrives more than 15 minutes past their scheduled time we may have to reschedule your appointment.

3. Account Balances

Sometimes you missed that bill, or may be having a difficult time paying a balance. We are here to work with your. Families who have questions about their bill or would like to discuss a payment plan option should call our billing department at (401)723-5533

4. **How do I cancel my appointment?**

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. To cancel appointments please call (508)358-2918.

If you do not reach one of the secretaries, you may leave a message with our answering service. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

What is a "late cancellation"?

We use the term late cancellation when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

What is a "no-show" ?

The term "no-show" is for patients who miss an appointment without calling to notify the office in advance. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

Thank you for your cooperation,
Wayland Pediatrics

I understand the avove appointment policy. Any cancellations not made with appropriate notice would be charged to me personally, and cannot be submitted to my insurance company.

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Date:_____

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VACCINE POLICY

- We strongly believe in the safety and effectiveness of vaccines to prevent serious illness and to save lives. All infants, children and young adults should receive the vaccines according to the schedule supported by the Centers for Disease Control and the American Academy of Pediatrics.
- Vaccinating children and young adults may be the single most important health-promoting intervention we perform as pediatricians, and that you can perform as parents/caregivers. The vaccine schedule we use is the result of years of scientific study and data gathering on millions of children by our brightest scientists and physicians. It is precisely because vaccines are so effective at preventing illness that there is discussion about whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or known a friend or family member whose child died of one of these diseases. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to allay any concerns you have about vaccinating your child.
- Please know that delaying or "spacing out the vaccines" opposes expert recommendations, and places your child, other children and the community in general at risk for significant illness. If your child is not currently up to date on his or her vaccines we will create a written catch-up vaccine schedule with the goal of having your child caught up with all of the recommended vaccines in a period of 6-12 months, depending on the age of your child and how many vaccines are needed. We will ask you to sign this plan and it will become part of your child's medical record. **If you are unwilling or unable to comply with the vaccine schedule, you will be asked to transfer to another practice in order to protect our other patients, especially those with compromised immune systems.**
- (If you refuse to vaccinate your child despite all our efforts, we will ask you to find another physician who shares your views. We do not keep a list of such physicians nor would we recommend any such physician.) As medical professionals, we feel very strongly that vaccinating on schedule is the right thing to do for all children, adolescents, and adults! Please recognize that by not vaccinating, you place your child at unnecessary risk for life-threatening illness and disability, and even death. Thank you for reading this policy, and the trust you place in us. Please feel free to raise any questions or concerns you may have about this policy with one of us.

Maya Dor, DO

Ellen Mahoney, MD

Nancy A. Crowley, CPNP

73 Pelham Island Road • Wayland, MA 01778 • (508) 358-2918
www.WaylandPediatrics.com

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For your convenience please send this to your previous physican.

I, _____, hearby authorize my complete
(patient's name)

Medical records to be release to Wayland Pediatrics on this date_____.

Patient or Parent if minor Signature_____

Printed name_____

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WWW.WaylandPediatrics.com
Phone (508)358-2918 fax (508)358-6054