



DALLAS PEDIATRICS

& ID ASSOCIATES

1120 S. Main Street • Suite 100
Grapevine, Texas 76051

OFFICE 817.416.5554 FAX 817.416.5556

Standard Policies

- **Authorized Persons:** We expect each child to be accompanied by their parent or legally appointed guardian when coming in for their well-child and sick appointments. In case someone else needs to bring the patient in for their appointment then we encourage you to have a signed authorization on file naming persons authorized to bring the child in for treatment.
- **Deductibles:** The parent / guardian are responsible for the any deductible that your insurance plan has in place.
- **Payment Due:** Please be reminded that payment is due at the time of service. Our front office can accept checks, credit cards and cash.
- **Respect & Courtesy:** We strive to provide professional, courteous & caring service to all our patients and their parents / guardians. We expect the same level of respect for our staff who is caring for you.
- **No Walk-ins:** We do not offer walk-ins. However for your convenience we offer same day sick appointments in most cases. Please call 817-416-5554 starting at 8AM Mon-Fri.
- **Missed Appointment:** Please call 24 hrs. in advance if you will not be able to make an appointment. We reserve the right to charge no-shows. If you miss more than 3 appointments you will be considered non-compliant and we will not be able to give you future appointments.
- **Late to appointment:** If you late to your appointment we may not be able to see you that day and may have to re-schedule your appointment.
- **Refills:** Medication refills must be requested Monday-Friday between 9AM – 4PM.
- **Secondary Insurance:** We do not accept Medicaid as secondary insurance when primary insurance is Private. You must pay all deductibles.
- **Medical Records:** Transfer of medical records to another physician is free of charge, however we do charge a minimum of \$25 for medical records request for any other purpose.

I understand and agree with the policies listed above and agree to abide by them as long as my child is a patient.

Patient Name: _____ Date of Birth: _____

Parent Name: _____

Signature: _____ Date: _____