

PEDIATRICS PLUS, P.C.
3312 HENRY ROAD
ANNISTON, AL 36207
(256) 241-2671

PATIENT REGISTRATION INFORMATION

PATIENT NAME: _____ DOB: _____

Gender: _____ SS# _____ Patient Lives With: _____

Race: _____ Language: _____ Hispanic: Yes / No Email: _____

Address: _____

Preferred method of contact: Mail: _____ Phone: _____ Patient Portal: _____ (Patient Portal is designed for you to see certain medical information about your child, request to schedule appointments, etc. via the internet.)

PARENT INFORMATION:

Mother's Name: _____ DOB: _____ Father's Name: _____ DOB: _____

Home Phone: _____ Cell Phone #'s: _____ / _____

SS#'s (Mother/Father) _____ / _____ Work Phone #'s: _____ / _____

Employers for Parents: _____ / _____

DHR or Other Custody (GM, GF, Aunt, etc.): _____ Phone: _____

DHR Caseworker: _____ County: _____ Phone: _____

Insurance Name (Policy # & Group #) or Medicaid Number: _____

Insured and/or Subscriber (Person carrying insurance): _____

Name of Person(s) other than Parent to contact in Case of Emergency:

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

By signing below, I agree to be responsible for charges not covered by my insurance including but not limited to copays, deductibles, coinsurance, non-covered services, not insured, and underinsured. These charges are to be paid at the time service is rendered.

I authorize Pediatrics Plus, P.C. to release my child's medical record to my insurance company, if requested, for payment of claims. I authorize Pediatrics Plus, P.C. to release my child's medical record to the physician/specialist my child may be referred to for continuity of treatment.

You agree, in order for us to service your account or to collect monies you may owe, Pediatrics Plus, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I/we have read this disclosure and agree that Pediatrics Plus, P.C., its employees and/or agents may contact me/us as described above.

AGREEMENT TO PAY: I, undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary.

Signature

Date

Pediatrics Plus, PC

3312 Henry Road

Anniston, AL 36207

Phone: (256) 241-2671 • Fax: (256) 241-2676 / (256) 770-4832

Medical Record Release Form

By signing this form, I authorize the following to release my confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the facility / entity listed below.

Patient Name: _____ Date of Birth: _____

Name / Facility: _____

Address: _____

Phone: _____ Fax: _____

The information you may release subject to this signed release form is as follows:

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Treatment Record | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Hospital Reports |
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Other (please specify below) |

Release my protected health information to the following facility / entity:

Pediatrics Plus, PC
3312 Henry Road
Anniston, AL 36207-6344
Fax: (256) 241-2676 / (256) 770-4832

Information that is being released may be (check all that apply): Faxed: _____ Mailed: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV- related information, mental health related care, or substance abuse diagnosis and treatment information require additional authorization.
- There may be a charge for the requested records.
- This authorization expires on ___/___/___, if left blank, expiration date will be 90 days from the signature date.

Signature:

Patient Name

Signature of Patient or Representative

Witness

Printed Name of Patient or Representative

Date

Description of Representative's Authority (Mom, Dad, etc)

3312 Henry Road
Anniston, AL 36207

P: 256-241-2671
F: 256-241-2676
F: 256-770-4832



Chase E. Thomas, CRNP
Elizabeth Patrenos, MD, FAAP
Holly F. Mays, CRNP
Katie C. Smith, CRNP
John R. Loper, CRNP
Blaire C. Smith, CRNP

As a courtesy, we would like to provide you with a list of charges you will be required to pay while you are a patient at our practice:

- 1- Copay / Deductible / Co-Insurance / Non-Covered Services
- 2- Balances on your account (current and past due)
- 3- \$5 (Cash) each Form (“blue” immunization, sports physicals, daycare, etc. when requested at times other than appt.)
- 4- \$25 FMLA paperwork
- 5- Medical Records (\$6.50 flat fee)

As these are the most common reasons for payment, there may be additional fees you acquire. We appreciate the opportunity to care for your child.

Thank you,

Pediatrics Plus, PC

Signature: _____

PEDIATRICS PLUS, P.C.
PERMISSION FOR CHILDREN TO BE SEEN WITH
NON-PARENT/GUARDIAN

Patient's Name: _____ Date of Birth: _____
 Patient's Name: _____ Date of Birth: _____
 Patient's Name: _____ Date of Birth: _____
 Patient's Name: _____ Date of Birth: _____
 Patient's Name: _____ Date of Birth: _____

Pediatrics Plus, P.C. can no longer treat your child by telephone or in person without a biological parent or guardian present in a non-emergency situation. The only exception to this is if Pediatrics Plus, P.C. has this form on file. You may fill it out in our office and let a member of our personnel witness your signature. Another option is to have this form notarized by a Notary Public and either mail it back to us, 3312 Henry Rd., Anniston, AL 36207, or bring it by our office. We also have a Notary Public on staff if you wish to have it notarized.

The following people have permission to bring my child to Pediatrics Plus, P.C. to be seen and to call the triage staff of Pediatrics Plus, P.C. to get medical information via the telephone for my child; examples would be grandparents, babysitters, or other family members or friends that might bring the child to the doctor for you or need to call our office regarding your child or make payments for you. They have full authority to act in my behalf should authorization be necessary for testing or treatment (i.e. labs, x-rays, etc.). They may also receive financial information such as the balance on my account. I understand that if any person who is not on this list, calls Pediatrics Plus, P.C. or brings my child to Pediatrics Plus, P.C. except in the case of an emergency, Pediatrics Plus, P.C. will not speak with this person nor see my child in your office. I understand that it is my responsibility to ask for and fill out a new form if any of the following people should be removed. I understand that I can ask that the following people not be given any financial information regarding my account and I will note this restriction beside their name below if I do not want them to receive this information.

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____
Name of Parent/Guardian	Date
_____	_____
Signature of Parent/Guardian	Witness/Notary
_____	_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
 Effective Date of Notice: September 7, 2010

I acknowledge that I have received Pediatrics Plus, P.C.'s Notice of Privacy Practices.

_____	_____
Signature of Patient/Parent/Legal Guardian	Relationship to Patient
_____	_____
Print Parent/Legal Guardian's Name	Date

____Keyed
 ____Scanned

Appointment Reminders, ETC.

We may contact you by sending text messages/emails, using any cell number or email address you provide to us to remind you of your appointment. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. You agree Pediatrics Plus, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

You also agree, in order for us to service your account or to collect monies you may owe, Pediatrics Plus P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

I/we have read this disclosure and agree that Pediatrics Plus P.C., its employees and/or agents may contact me/us as described above. Please provide us with the information listed below:

Patient Name/DOB: _____

Phone Carrier: _____ Cell #: _____

Email Address: _____

No Show Policy

Due to the increased amount of patients not showing up for their appointments, we have a new “**No Show**” policy at Pediatrics Plus. By not calling and canceling your child’s appointment, you are taking time away from another family and their child. We understand that there are times that you are unable to make your appointment. All that we ask is that you call the office and let us know that you are going to be unable to make your child’s appointment. Effective immediately, if you “**No Show**” for **3 appointments** in one year, then we will be forced to dismiss you from our practice. A \$25 fee per child will be charged for patients who do not show up for any scheduled appointment.

Please give three **GOOD** phone numbers so that we can continue to remind you of your upcoming appointments.

Number 1 _____

Number 2 _____

Number 3 _____

Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES
PEDIATRICS PLUS, PC
Effective date: September 7th, 2010

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY**

If you have any questions about this notice, please contact the practice manager at (256) 241-2671.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment. We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, your insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit.

For Health Care Operations. We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff caring for you.

CONSENT FOR TREATMENT POLICY

It is the policy of Pediatrics Plus, P.C. that either parent may consent for treatment of their child. In the event the parents are divorced, both parents still have consent for treatment of their child unless one or both parents have lost parental rights to the child. In this case, parents must provide Pediatrics Plus, P.C. with court orders. Also, if parents are divorced and one parent is the primary parent for “medical decision making”, this does not legally change the right of either parent to consent for medical treatment, unless one parent or both have lost parental rights of the child.

If the child is placed with a temporary guardian, i.e. grandparent, etc., parent(s) must delegate powers by providing Pediatrics Plus, P.C. with an Executed Power of Attorney that shall remain in effect for no more than one year. A temporary guardian does not require court approval but a Power of Attorney must be notarized. If a child is placed in DHR custody or a safety plan, court orders and/or documentation must be provided to Pediatrics Plus, P.C.

A permission form must be signed by Mom, Dad, or Legal Guardian (court ordered) granting permission for a non-parent or guardian to consent for medical treatment of the patient. If a person that is not listed on the permission form brings a child to the office, verbal consent must be given by calling a parent for consent. Mom and/or Dad must identify themselves by something personal on the chart; i.e. social security number, driver license #, etc. This verbal consent must be documented by employee in patients’ chart.

Minor patients 14 years or older must sign a Medical Records Release giving Pediatrics Plus, P.C. permission to disclose Protected Health Information to parent(s) or any other person they so choose. Minor patients 14 years or older must also understand that if claims for treatment are to be filed on the parents’ insurance, any PHI they do not want disclosed is beyond our control.

THIS IS YOUR COPY TO KEEP

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Anniston, AL 36207

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Chase E. Thomas, CRNP
Elizabeth Patrenos, MD, FAAP
Holly F. Mays, CRNP
Katie C. Smith, CRNP
John R. Loper, CRNP

Policy Effective July 16, 2018

The CDC recommends a specific vaccination schedule for all children. Though vaccinations are required by the school system, each family still has the option to opt out of vaccinating their children or choosing a delayed/split vaccine schedule. Though many Pediatric Practices (Children's Hospital of Alabama included) will not see children who are Under Immunized and those who are not immunized, we here at Pediatrics Plus will continue to see those children. However, if your family chooses not to follow the CDC's recommended vaccination schedule, whether that be by choosing a delayed/split schedule or to not vaccinate your child at all, your child will be seen in our Urgent Care/Sick Clinic. In other words, if your child would not be admitted to public school or daycare because of their immunization status they will not be seen in the well building. We will no longer see children on delayed/split schedules in the Wellness Clinic until they are up to date on their vaccinations according to the CDC. Below is the vaccination schedule the CDC recommends:

- Birth---Hepatitis B***
- 2 Months---Hepatitis B***, (DTaP / HiB / IPV), PCV, RV
- 4 Months---(DTaP / HiB / IPV) PCV, RV
- 6 Months---(DTaP/ HiB / IPV), PCV, RV, Hepatitis B***. Children are also able to get the Influenza shot at this age.
- 12 Months---Varicella, MMR, Hepatitis A***
- 15 Months---DTaP, HIB, PCV
- 18 Months---Hepatitis A***
- 4 Years---(DTaP / IPV), (Varicella / MMR)
- 11 Years---Tdap, HPV***, MCV***
- 16 Years---MCV***, Meningitis B***

***Not required but recommended.

We truly appreciate you entrusting our Practice with your child's health care. We take great pride in the care we give to our children and hope to continue being your Pediatric Practice of choice.

Pediatrics Plus, PC

GENERAL OFFICE POLICIES

Registration/Demographic Information: At least annually, we are required to obtain updated information from each patient which authorizes our clinicians to provide continuous medical services to that patient. Our policy is that all new patients must complete patient information forms prior to being seen and established patients must update the information sheet every year or whenever there is a change.

Privacy: A copy of our Notice of Privacy Practices is available to all patients in accordance with HIPAA (Health Portability & Accounting Act of 1996). This documentation can be found in our patient registration packet.

Minor Patients: A parent or legal guardian must accompany any minors to receive medical care services at our practice. Written authorization allowing other persons to accompany patients to office visits must be provided on the Permission for Children to Be Seen with Non-Parent/Guardian form. We may deny care unless this policy is followed.

Adolescent Consent: Adolescents age 14 and older may be requested to sign a release of information form. Some exceptions are made for emergencies as listed under Ala. Code Sec. 22-8-1, Ala. Code Sec. 22-8-3, Ala. Code Sec. 22-8-4 and Ala. Code Sec. 22-8-6.

Transition Age: It is our recommendation that once adolescent patients reach age 19 and/or graduated from high school, he/she should find an internal or family medicine provider that can give adult medical care.

Patient Portal: Our front office or clinical staff will assist patients with Patient Portal access and instructions. Each patient is given a unique login per child. This system gives our patients a convenient way to access information such as labs, office visit information, and a way to send messages to your care team.

Call-backs: If you leave a message and expect a call-back, be sure to speak clearly, leaving a detailed message with the patient name and date of birth, reason for the call, person calling and best call-back number. Your call will be returned promptly by the appropriate team member.

Prescription Refills: Our prescription refill line is available during normal business hours Monday-Friday. Please allow 24 hours for processing. Medications for ADD/ADHD, Asthma, and some other medications may not be refilled if your child has not been in the office for a medication management visit within the last three (3) months.

Referrals: Most managed care insurance plans require referrals from your primary care physician before your child can be seen by a participating specialist. It is necessary to ask parents to provide us at least three (3) to five (5) business days for a referral to be completed and forwarded to the specialist. Our Referral Specialists are available during normal business hours Monday-Friday.

Nurse Line: Our nurse line is available during normal business hours Monday-Friday. This service is for questions you may have about your child's health and for advice regarding minor medical issues. This line is not intended for routine questions that can be asked during your visits to our office or to schedule appointments.

Appointments: A parent or legal guardian must be present for the initial visit to receive medical care at our practice. Please be prepared for all appointments by having your insurance card, a photo ID, and filling out any necessary forms prior to seeing the Doctor/CRNP. Same-day appointments are available for sick appointments only. Appointments can be scheduled by calling our main office line during normal business hours Monday-Friday.

Late or Missed/No Show Appointments: *If you are unable to make your scheduled appointment, you must notify our office 24 hours prior to your appointment. Missing three (3) scheduled appointments in a year will result in dismissal from the practice. If you are running late, you should immediately call our office to determine if we must reschedule. Patients 15 or more minutes late for any appointment regardless of the reason will either be asked to reschedule and/or may be worked in when a provider is available.*

After-Hours: *Our providers are on-call after normal business hours through our on-call system by calling the office line. The on-call system will be answered by the answering service and will route your call or message to the nurse on call. This service is for urgent problems that can't wait until the next business day (no medicine refills, appointments, or routine questions, please!).*

Emergencies: *We recommend all parents learn CPR and keep emergency numbers handy. Call 911 for life-threatening emergencies or go to your nearest emergency room. Ask the ER staff to contact our office upon arrival. For poisoning, call The Regional Poison Control Center Children's Hospital at 1-800-222-1222 for poison advice for all ages.*

Medical & Immunization Records: *Medical records must be requested in writing and signed by a parent or legal guardian. Immunization Records may be requested by phone. Please speak to our Front office, Billing office, Triage Nurse, or Medical Records Clerk for questions regarding fees for records. All records can be picked up at the office.*

Dismissal of Patient-Practice Relationship: *Our Practice may terminate a relationship with a patient at any time. If this happens, the patient will receive a certified letter explaining the reason for dismissal. The Practice will provide the patient access for 30 days of service for urgent medical matters only. Our practice reserves this action for patients who demonstrate a lack of respect for their medical services and the practice by missing appointments repeatedly, disregarding the practice's stated policies, or behaving in a way that is deceptive, disrespectful, dishonest, rude or abusive to the employees of Pediatrics Plus.*

Pediatrics Plus, PC

FINANCIAL POLICY

PRIVACY: A copy of our Notice of Privacy Practices is available and given to all patients in accordance with The Health Portability & Accountability Act of 1996 (HIPAA). (Included with original Registration material)

INSURANCE CARD: We must have a copy of your current health insurance card on file and please be prepared to show your insurance card at each visit. Insurance eligibility must be verified prior to seeing the Doctor/CRNP or you will be required to pay at the time of service. If there is a change in your insurance coverage, please notify us promptly. Most insurance companies have limits on the amount of time we have to file a claim. If we do not have the correct information, we cannot file the claim in a timely manner.

INSURANCE: Our office accepts assignment of insurance benefits from most major insurance companies for payment of services rendered. The responsible party must verify specific coverage for our Physician/CRNP's and the specific policy before treatment. Refer to our Billing & Insurance Policy for a list of **in-network** insurance plans and payment methods accepted. Our business office will assist you with coverage questions related to your insurance plan.

CO-PAYMENTS: Our Physician/CRNP's are contractually obligated per your insurance company to collect a co-payment at the time of service. Your insurance policy and the agreement between your Physician/CRNP and the insurance company requires we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay cannot be paid at the time of service, your appointment may be rescheduled.

SELF-PAY: If there is no medical coverage at the time of service or our Physician/CRNP is out-of-network with your insurance, then the responsible party is liable for all charges incurred at the time of service. The business office will assist with the amount due and provide a copy of any itemized billing statement for insurance or tax purposes.

NEWBORNS: If newborn patient charges are incurred, then it is the parent's responsibility to add the newborn to your insurance policy or another acceptable policy within 30 days of the date of birth. If no insurance is acquired, then the parents or responsible party will be liable for all newborn office visit charges incurred until insurance is in force.

BALANCES & DEDUCTIBLES: In the terms of our contracts with health insurance companies, we are responsible for collecting at the time of service and/or billing you any portion of your treatment that your health insurance carrier does not pay/cover. You are responsible for paying this portion of your bill. All balances are due at time of service or upon receipt of your financial statement. Failure to pay could result in collection activity or dismissal from the practice. Your child's appointment may be rescheduled if you are not prepared to pay any balance (current or past due) and/or deductibles at the time of service. In the event of a returned check for insufficient funds, your account will be charged \$10. Refunds will be issued on accounts with a credit of \$50 or more. Any account with credits less than \$50 will have funds held for future visits unless otherwise authorized by the business office.

PAYMENT PLANS: We understand at times families may experience financial hardship and we do offer payment plans. Your first payment will be due upon signing a written agreement. Payments are based on the amount owed. No payment plan will be given to amounts less than \$100. If your payment plan is in default, the balance will be due in full. Failure to pay may result in collection activity and/or dismissal from the practice.

NO RESPONSE CLAIMS: If your insurance company does not respond to the claim within ninety (90) days from the date of the claim, you are responsible for the payment of the bill.

MEDICAID INSURANCE: We accept Alabama Medicaid Insurance. Children with Medicaid Insurance are allowed fourteen (14) visits per calendar year (does not include wellness visits). Children are allowed nine (9) well visits prior to age 2, and one (1) well visit per calendar year age 2 and above. Once you reach fourteen (14) visits in a calendar year, you are

responsible for the payment in full for each visit thereafter until the end of the year. ER visits for routine health problems may count as a doctor visit. Using one doctor and one pharmacy is best for your child's health.

AGREEMENT TO PAY: The parents or responsible party must agree to pay any account balance. In case of a default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees (33.33%), attorney's fees, court costs and all other expenses related to the collection of the outstanding balance will be paid by the responsible party. You agree, that for us to service your account or to collect any amount owed, Pediatrics Plus PC and/or its agents may contact you by telephone at any telephone number associated with the account, including wireless telephone numbers, which could result in charges. We may also contact you by sending text messages and/or emails, using any mobile number or email address provided for our use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing devices, as applicable.

CONVENIENCE FEE: Effective September 1, 2022, a convenience fee of 3% will be added to all Debit and Credit Card transactions. This fee percentage amount is subject to change at the discretion of Pediatrics Plus, PC. A notice will be posted if such a change.

BILLING & INSURANCE

We accept most insurance companies, including Alabama Medicaid and All Kids. For any questions, you may have regarding billing information, please call our billing office at (256)241-2671, option 3.

Payment of copays, deductibles and non-covered services are due at the time of service. Please make sure to bring an updated insurance card, a photo ID and payment. We accept cash, personal checks, Visa, MasterCard, Discover and American Express.

Please review our **Financial Policy** and the following list to make sure we accept your insurance plan:

- Blue Cross Blue Shield
- All Kids
- Alabama Medicaid
- Aetna
- Cigna
- Coventry / First Health
- United Health Care (UHC)
- PCHS / Multi Plan
- Tricare
- Viva

Forms of Payment

Payments for services are accepted by certified funds, cash, checks, debit or credit cards. Currently we accept the following credit cards.



Master Card

Visa

American Express

Discover

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ZERO TOLERANCE POLICY

Pediatrics Plus is a healing environment and intended to be a place of safety. Aggressive behavior directed towards our staff or another patient will not be tolerated.

Examples of aggressive behavior include:

- Physical assault
- Verbal harassment
- Abusive language included but not limited to profanity
- Sexual language directed at others
- Threats of any kind
- Hate speech
- Destruction of property

There is ZERO TOLERANCE for all forms of aggression. Any incident may result in removal from this office by staff or police, dismissal from the practice, and prosecution.

Pediatrics Plus, PC

ATTENTION

PATIENTS AND VISITORS

OUR OFFICE IS A HEALING ENVIRONMENT.
AGGRESSIVE BEHAVIOR WILL NOT BE TOLERATED.

Examples of aggressive behavior include:

- Physical assault
- Verbal harassment
- Abusive language including profanity
- Sexual language directed at others
- Threats
- Hate speech
- Destruction of property

THERE IS ZERO TOLERANCE FOR ALL FORMS OF AGGRESSION.
INCIDENTS MAY RESULT IN REMOVAL FROM THIS OFFICE,
DISMISSAL FROM THE PRACTICE, AND PROSECUTION.

PEDIATRICS PLUS, PC