Practice Policies and Procedures - 2026

Thank you for choosing Adventure Pediatrics as your child's health care provider. The following is a copy of our practice policies and procedures. Before we can care for your child, we need your written acknowledgement that you have received and understand this information. The policies will apply to every child in your family. Initial each section below to show that you have read and understand it.

Well Visits and Vaccines

At Adventure Pediatrics we recognize the importance of routine well check-ups and follow the schedule recommended by the American Academy of Pediatrics (AAP).

- Newborn (3-5 days of life)
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months (2 ½ years)
- 3 years and up - on an annual basis

We expect our families to follow these guidelines so that we may provide quality healthcare to our patients. Failure to do so may result in dismissal from the practice. A grace period of up to 3 months will be applied for annual check-ups; after this, patients will be marked as 'inactive' and will need to re-enroll. Adventure Pediatrics requires that our patients follow the immunization schedule recommended by the AAP. Insurance companies may differ in how they define and cover preventative services; as such, you may be responsible for out-of-pocket costs, such as deductibles, copays, or charges for non-covered services. Please review your insurance plan carefully to understand which preventative services are covered, and how often, before receiving care. A list of recommended screenings and labs can be found on our website, under Bright Futures Periodicity Schedule; a paper copy can be provided upon request.

Initials: _____

Patient Privacy

The team at Adventure Pediatrics is governed by and complies with the federal Health Insurance Portability and Accountability Act (HIPAA). We must abide by the terms of our office Privacy Policy. We may change the terms of this policy at any time; the most current copy may be found on our website adventure-pediatrics.com, or a paper copy can be provided on request. The new notice will be effective for all protected health information that we maintain. A copy of our current HIPAA statement is available upon request. Patients aged 18 and older must sign a waiver authorizing parental access to their account. Parents of patients over 18 will not be permitted to access any medical or billing information without this written consent.

Initials: _____

Missed Appointments

We require a 24-hour notice for cancellations. Repeated same day cancellations or missed appointments, per family, may result in dismissal from the practice.

Initials: _____

Late Arrivals

Appointment arrivals 10 minutes or later than the scheduled appointment time may result in the need to reschedule the appointment. Appointment dates and times can be found by logging into your patient portal.

Initials: _____

Records Requests

If you wish to obtain a copy of your medical records you must complete the authorization to release records form, available at **adventure-pediatrics.com**; a paper copy can be made available at the office. The form must be completed in its entirety to process the request. A summary of care can be provided at no cost, but any outstanding balances must be paid before the patient's full medical record can be transferred.

Initials: _____

Form Requests

Forms requested before or on the day of an appointment will be provided within 24 hours of the exam date. Forms requested after the date of the appointment will take up to 5 business days to complete. Some complex forms, such as Family Medical Leave Act paperwork, may require additional time.

Initials: _____

Medication Refills

Medication refills will be renewed at the appropriate follow up appointment or wellness exam. If the appointment is rescheduled, we will renew one month to allow time for the new appointment. If the appointment is missed, or rescheduled more than once, your child will need to be seen in the office before additional prescriptions will be sent. If your child has unexpectedly run out of an "emergency" medication, such as an asthma inhaler, and is experiencing symptoms, please contact the office.

Initials: _____

Divorce/Separation

By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

Initials: _____

Respect

Treat Adventure Pediatrics team members with respect, and refrain from language or behavior that is offensive, abusive, or intimidating.

Initials: _____

Family Dismissal

Adventure Pediatrics reserves the right to terminate the patient/practice relationship at any time due to violation of practice policies.

Initials: _____

Financial Policy - 2026

Thank you for choosing Adventure Pediatrics as your child's health care provider. The following is a copy of our financial policy. Before we can care for your child, we need your written acknowledgement that you have received and understand this information. This policy will apply to every child in your family. Initial each section below to show that you have read and understand it.

Payments

Payment in full is due at the time of service. This includes applicable co-insurance, co-payments, payments for services not covered/denied by your insurance company. Make sure that if you are unable to bring your child in yourself, that whoever brings the child in is prepared to make all payments.For your convenience, we accept all major credit/debit cards and checks. If a check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment and will be subject to a $35 returned check fee.

Initials: _____

Self-Pay Accounts and Non-Covered Expenses

We offer a discount at the time-of-service for those without insurance or for non-covered charges, applicable only if paid in full on the day of service. This discount does not apply to the "patient responsibility" portion of covered charges, as these are discounted through your insurer's contract.

Initials: _____

Insurance

We accept most major insurances and Mississippi Medicaid plans. A current list of accepted insurance can be found at adventure-pediatrics.com, though we strongly encourage you to verify that we are in-network for your particular plan. A scanned copy of the assigned account holder's current insurance card and driver's license is required to be kept on file; in addition, you will be asked to present your insurance cards at every appointment, even if we already have a scanned copy.

Initials: _____

Change of Insurance or Account Information

Please notify the office as soon as possible regarding any account changes, insurance updates, or change of mailing address or other contact information.

Initials: _____

Outstanding Balances

Our billing partners will communicate with you primarily through the portal regarding any personal/outstanding balances. Paper statements will be sent if multiple attempts to reach you are unsuccessful, or upon request. For billing questions, contact the office by portal message or phone.

Initials: _____

Review and consent of these policies is required prior to services rendered

Please list all children that are patients of Adventure Pediatrics. This signed document will apply to all children listed below; copies will be saved to each chart.

First Name: _____ Last Name: _____ Birth Date: __/__/____

First Name: _____ Last Name: _____ Birth Date: __/__/____

First Name: _____ Last Name: _____ Birth Date: __/__/____

First Name: _____ Last Name: _____ Birth Date: __/__/____

First Name: _____ Last Name: _____ Birth Date: __/__/____

First Name: _____ Last Name: _____ Birth Date: __/__/____

My signature below certifies that I have read and consent to the Practice Policies and Procedures and Financial Policy.

_____ _____ __/__/____

Signature of parent/guardian Printed name of parent/guardian Date