Patient Responsibility/Financial Policy Statement

Patient Name: ________________________ DOB: ___________ Acct#: ____________

Payment Policy

CareVille Pediatrics, P.A requires payment of all known patient responsible balances **at time of service**. These balances may include but are not limited to co-pays, deductibles or co-insurance (amounts as states in the benefits coverage contract with your insurance carrier.) any amounts due for patients who are "self-pay/private pay"; any amounts due from previous dates of service, or amounts that may be incurred during your current visit. CareVille Pediatrics, P.A accepts cash, checks, Visa, MasterCard and American Express as forms of payment for your convenience. If your check is returned to CareVille Pediatrics, P.A for insufficient funds, a thirty dollar ($30.00) returned check fee will be applied to your outstanding balance.

______ (Initials)

Insurance Policy

We will require a copy of your insurance card and driver's license at the time of your arrival. CareVille Pediatrics, P.A will bill your insurance company as a courtesy to you, but this billing service does not dismiss your financial responsibility for the services received. Any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. Please understand that your insurance policy is a contract between you, your employer and your insurance company. Our office will not enter in a dispute with your insurance company over policy limitations or issues If CareVille Pediatrics, P.A is not contracted with your insurance provider, CareVille Pedatircs P.A, as a courtesy, will submit claims to your carrier; any deductible, co-insurance or non-covered services including ineligibility are your responsibility. CareVille Pediatrics, P.A will mail monthly statements and contact you to collect any open balances. Please inform our staff immediately of any insurance changes.

_______ (Initials)

Non-Covered Service Policy

Certain services performed by our office, for your child's benefit, may **NOT BE COVERED** by your insurance plan(s). We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility.

_______ (Initials)

Delinquent Accounts Policy

Delinquent accounts will be reported to our collections department if a claim is unpaid after 90 days from the date of service following CareVille Pediatrics, P.A normal collection procedures to resolve any outstanding balances. Please inform our staff if you know your payment will be late in arriving or if you require payment arrangements. Any balance over 120 days will be sent to a collection agency unless arrangements have been made prior to the due date.

_______ (initials)

Late Arrivals

In order to keep our steady flow to see our patients in a timely manner, your help in arriving promptly for your appointment is required. If you are **more than 15 minutes late**, our staff will reschedule your appointment to a new date and time. We understand your time is valuable and will do our best to respect your time and see you as promptly as possible. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

______ (Initials)

Medical Records

Should you request a copy of your medical records or financial statements please allow or office 3-5 business days for completion. The charge for this service is five ($25.00) pages 1-5, then one dollar ($1.00) for each additional page.

______ (Initials)

Forms Policy

Should you request our office to complete forms on your child's behalf such as immunization records, disability forms, daycare, etc., there will be a charge of five dollars ($5.00) per form. Payment of this charge is expected at time of completion.

_____ (Initials)

Office Hours/After Hours Policy

Our office hours are Monday-Friday 8:00 A.M-5:00 P.M. We have an answering service available after hours that will contact the physician on call for that evening. If you call during this time, your number will be forwarded to that physician. Your call will be returned within 15 minutes. If your call is an emergency, dial 911.

_____ (Initials)

Prescription Refills

If you need refills, please contact your pharmacy first to notify them of what you need. Please notify your child's pharmacy at least 1-2 days before your child completes their medication. Prescription refills on controlled substance i.e. ADD, ADHD medication requires 7 days' notice to our office staff. If you fail to pick your prescription up with in the time allowed, a five ($5.00) charge will apply for a replacement of the prescription.

_____ (Initials)

Appointments/Cancellations/No Shows/ Reschedule

A parent or legal guardian must accompany all minor patients. Parents who no show for an appointment frequently without giving 24 hours' notice, may be dismissed from our practice. However, we understand unusual circumstances may arise, please contact our office as soon as possible.

_____ (Initials)

Referrals and Authorization

If a referral is required by your child's insurance carrier, you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. We suggest you contact your insurance carrier to verify your coverage, benefits and pre-authorization requirements prior to having any procedure performed. Claims are paid based on medical necessity. Please be aware authorization and referrals are not a guarantee of payment by your insurance carrier and remain your responsibility.

_____ (Initials)

By signing below, I hereby declare I'm the parent/guardian for the child listed above. I have read and understood all office policies and take full responsibility for all my child's medical and financial obligations.

Patient Name:______________________________ DOB:________________ Date:________________

Parent/Guardian Printed Name: ________________________ Parent/Guardian Signature: ____________________

Date: __________________