**PEDIATRIC EYE CARE & SURGERY**
**Sarah J. Whang, M.D.**

**FINANCIAL POLICY FOR CASH PATIENTS**

**Child's Name**:_____ **Child's DOB**:_____

_____ Initials I understand that Dr. Whang will not bill any insurance plan (i.e. Medi-Cal, Medi-Cal managed care plans, Medicare, private insurance or any other insurance) for my child's care.

_____ Initials I certify that my child is not enrolled in Medi-Cal.

_____ Initials I certify that my child does not have a pending application for Medi-Cal.

_____ Initials I agree to pay for today's services in full prior to leaving the office.

_____ Initials A rescheduling fee of $50 will need to be paid in order to reschedule a missed appointment for which 24 hours advance notice has not been given, regardless of whether or not the courtesy reminder texts/emails were received. A voicemail message left 24 hours in advance will serve as adequate notice. It is my responsibility to inform the office of any changes in my phone number. The rescheduling fee is subject to change.

**I certify that I have read and fully understand and accept the above financial policy.**

Signature of Responsible Party: _____

Please print Name of Responsible Party: _____

Relationship to Patient: _____Date Completed: _____