Hospital Drive Pediatrics Financial Responsibility Disclaimer 01/2015

CO-PAYMENT AND DEDUCTIBLE: You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your insurance co-payment is always due at the time of service.

INSURANCE CARD: If you come in without your insurance card, you will be asked to cover the charges at the time of service in form of cash or check. We will be happy to bill your insurance for you if you provide us with a copy of your card, and a refund will be issued to you when your health plan makes payment on your claim.

NON-COVERED SERVICES: If we provide services to your child/children that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature below constitutes agreement to pay for such services. No matter what type of plan you have, it is your responsibility, to know and understand your coverage. Not all services are a covered benefit in all contracts. Contact your insurance company to find out what benefits are covered or excluded under your plan.

APPOINTMENT CANCELLATION CHARGE: A partial appointment fee of $40.00 will be charged for appointments cancelled without a minimum of 24 hours notification. In order to allow sufficient time for your appointment, as well as for other patients, **please arrive promptly for your appointment time.** Be aware that if you are more than 10 minutes late, we may need to reschedule your appointment to another day.

AFTER HOURS NURSE ADVICE: There is a service charge for each phone call made to our pediatric *After Hours* nurse advice line. Currently that charge is **$20.45**, but is subject to change at any time. *After Hours* advice is available when the office is closed.

REFERRALS: When this office makes a sub-specialist, radiology or lab referral for you, it is your responsibility to verify if a physician or facility is participating in your insurance network as a contracting provider, in order to obtain your maximum benefits.

PAST DUE BALANCE FEE: Once your insurance company has made payment, your portion will be billed to you and is due within 30 days of the date of the statement. **A fee of $10.00** will be applied to any unpaid balance that exceed 30 days past due. Your account may be turned over to a collection agency if your unpaid account balance exceeds 90 days.

IMMUNIZATION CARD REPLACEMENT: A charge of $10.00 for replacement cards.

FORM FEE: There is a $15.00 fee per request, which will be waived if you bring the forms at the time of your child's well child visit or routine medication follow-up visit (i.e. Asthma medications, ADD medications, other chronic medications.) We will not fill out forms at "sick" visits.

COLLECTIONS: If it is necessary to assign your account to a collection agency and/or an attorney, you will be responsible for all associated fees and costs.

RETURNED CHECK FEE: The fee for a returned check is $20.00, in addition to the original amount of the check. This charge covers our bank fees as well as additional processing and billing costs.

MEDICAL RECORDS: We require a signed written request to copy a patient's chart, and will provide copies within 15 days. There is a minimal processing fee of $15.00 that must be collected prior to releasing the records.

PATIENT TERMINATION: The office values its patient relationships and it wants to protect all patients' rights. We will only terminate patient relationships with cause and after careful consideration. Reasons for termination include: Repeatedly not showing for scheduled appointments, not complying with recommended medical care, being hostile or abusive to staff, not making an attempt or neglecting to pay your account in a timely manner.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____ Child's Name: _____