Office Policy Summary (2026)

Please Initial All

_____ **Account Balances**: **Due at check in for all family members accounts**.

_____ **Waiting Rooms:** Upon arrival, please enter the "Well Waiting Room" or the "Sick Waiting Room". We ask that you use the "Sick Waiting Room" if the patient or parent has any symptoms that may be contagious, for example, cough, nausea, etc. Note that limited cell phone use in the waiting room area is allowed, but use of any electronic devices in exam rooms are prohibited. Masks are optional in our offices.

_____ **Well Visits/Sick Visits:** Most insurance companies do not allow well and sick/office visits on the same day; To avoid being unexpectedly billed for an unallowable charge, our policy is have either a well or sick/office visit, but not both, on any given day; If you have a scheduled well visit and your child is ill or has a condition that would require a sick/office visit, please notify us at check-in and we will change your appointment to a sick/office visit. If, after conducting a well visit, we are requested to treat any medical situation you may be responsible for additional services beyond the well visit. I understand that I am responsible for the cash pay price of any vaccinations/injections requested and drawn up but then not administered due to refusal of patient and/or parent. Also note that the provider may send patient specimens to independent outside labs for analysis and that you may be billed for these services by the lab.

_____ **Billing Codes**: We are legally obligated to assign billing codes at the time of the service based on the services provided.

_____ **Inappropriate language**: **Will not be tolerated in our office or on phone calls with our staff. Such behavior will result in termination of provider/patient relationship.**

_____ **Insurance Policies**: **You are responsible to understand your insurance policy.** For deductible and co-insurance plans, if not charged at time of visit you will be billed monthly after processing by your insurance company. You are responsible for any services not covered by your plan. Please call our billing office if you have any questions. **You are responsible for updating us with new address, phone number and insurance information.**

_____ **After Hours Fee**: Applies to weekday appointments after 4:30PM and anytime on Saturday; Patient responsibility if not paid by your insurance company; Cash pay amount is $50.00.

_____ **No Show Policy**: Cancellations require 24 hours advance notice; **A $50.00 fee will be applied to your account if you no show or late cancel.** Note that if you are more than 15 minutes late for an appointment you may be required to reschedule and a no-show fee will be applied to your account.

_____**Forms:** We have established a fee of $50.00 for all Family and Medical Leave Act (FMLA), Handicap or Adoption forms and $25.00 for daycare, school and sports physical forms not brought in during a routine physical examination and other forms requiring the providers review and signature. Please allow five business days for these forms to be completed.

_____ **Payment Options**: We accept Visa, Master Card or cash at the time of your visit. Account balances may also be paid on-line or by check.

_____ **Late Payment/Collection Fees**: Statements are mailed monthly for all balances over $10.00; Payment is due upon receipt; A $20 fee will be applied to accounts that require a second billing cycle; A 40% collections fee will be applied to accounts that are sent to collections.

I understand and agree to the above policies and I have read and agree with the Office and Financial Policy and Notice of Privacy Policy of Valley of the Sun Pediatrics.

Parent or Guardian Name (Print): _____

Parent or Guardian Signature: _____Date: _____