



Office Policies

Insurance Policies

- ⇒ If insurance information/card is not presented at the time of service, patient will be considered self-pay.
- ⇒ To avoid claim denial please clearly state primary and secondary insurance, such as if insurance is primary with Medicaid as secondary.
- ⇒ It is your responsibility to keep us informed of your correct insurance plan. Please notify the office in a timely manner if there is any change in your insurance. If the insurance information is not correct or not provided in a timely manner, you will be responsible for payment of the visit and claim submission for reimbursement.

Financial Responsibilities

- ⇒ If SELF PAY, Financial Responsible listed above and/or undersigned will be responsible for all charges and payment in full at the time of service.
- ⇒ Financial Responsible listed above and/or undersigned is responsible for any amount not covered or paid by their insurance as well as Co-Pays, Deductibles, or Coinsurances at the time of service.
- ⇒ If we do not accept your insurance, payment in full is required at the time of service; an invoice will be provided for you to submit for reimbursement from your insurance.
- ⇒ Any balance due from prior visits will be due at the time of check-in. If a bill is provided, payments are due within 5 business days.
- ⇒ We accept cash and all major credit cards.

Appointments

- ⇒ We value your time and respectfully ask that if you are not able to keep an appointment, please notify the office with a 24 Hour advanced notice. Missed appointments will be charged a \$30 NO SHOW fee.
 - ⇒ At every visit/check-in, you will be required to present a valid government issued ID (Driver's License, Military ID, State ID etc.).
 - ⇒ If you are late for the <= 15 Minutes, we will try to accommodate as schedule permits. However, if you are more than 15 minutes late or if the schedule does not allow, appointment will be rescheduled.
- ⇒ I have read and fully understand the **Triangle Kids Care Pediatrics, PLLC Office Policies** and agree to abide by these policies.

Signatures

Date

Relationship to Patient

Witness Signatures

Authorization to Treat/Immunize

I _____ hereby authorize **Triangle Kids Care Pediatrics, PLLC** to treat and/or immunize my child as well as conduct routine checkups as recommended by the provider(s) at **Triangle Kids Care Pediatrics, PLLC**, within the guidelines set forth by the State of North Carolina.

Relationship: _____ Signatures: _____ Date: _____