



## Pediatrics Office and Financial Policy

*Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and sign at the end. If you have any questions, do not hesitate to ask a member of our staff.*

### Appointments

1. If you are not able to keep an appointment, we would appreciate a 24-hour notice. Appointments cancelled within 2 hours of your appointment time are considered a No Show. There is a \$40 No Show Fee.
2. If you are late for your appointment (>15 minutes) we will do our best to accommodate you. However, on certain days, it may be necessary to reschedule your appointment.
3. If you no-show more than 3 appointments, we may no longer be able to see you.

### Insurance Plans

*Please understand*

1. It is your responsibility to keep us updated with your correct insurance information.
2. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating labs.

### Referrals

1. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2. Remember, we must approve referrals before they are issued. If the referral is not for a known or recurrent issue, we may require your child to be seen prior to issuing the referral.

### Financial Responsibility

1. You are responsible for any and all co-payments, deductibles, and coinsurances.
2. Co-Payments are due at the time of service. We accept cash, checks, and credit cards.
3. Self-pay patients are expected to pay for services in full at the time of the visit.
4. If previous arrangements have not been made with our office, any balance outstanding for longer than 90 days will be forwarded to a collection agency.
5. A \$20 fee will be charged for any checks returned for insufficient funds.

### Forms

1. Form completion requires a notice of 2 business days

### Prescription Refills

1. We require a 48 hour notice during regular business hours for medication refills.

*I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.*

**KFP Patients** (list all siblings) \_\_\_\_\_

**Responsible Party's Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Responsible Party's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_