Kids First Pediatrics on 30

FINANCIAL POLICY

Payment for services rendered is due at time of service

♦ This includes copays and/or insurance deductible/patient portion deposits, any balance owed ♦

A major credit card, HSA (Health Savings Account), or debit card is required on all patient accounts

This policy applies to all children in your family, including those previously registered!

We will bill your insurance with the information you provide for all services received. It is up to you to know your insurance plan coverage. We will attempt to verify eligibility before your appointment, however this is not a guarantee of payment from your insurance company. Some or perhaps all of the services provided may or may not be covered by your insurance policy. For any amount not payable by your insurance company, a deposit for that estimated amount is required on date of service (or balance will be billed to card on account after processing). Your credit card, HSA or debit card on account will be billed for any amount due (noted as patient responsibility) not already left at time of service, when your claim is processed by your insurance company. If any unpaid balance is delinquent (over 30 days), you are responsible for any late fees, collection fees, attorney & court costs associated with recovery of monies due on the patient's account. There is a $20 collection preparation fee per patient account. You are responsible for any insurance balance not paid over 90 days from date of service. Our most current known contract amount will be charged to the patient account at that time. Any future payment from your insurance company will be refunded to your account. No later price adjustments will be made after 90 days. It is your responsibility to provide our office with your current demographic and insurance information for each patient. Also, it is your responsibility to provide any information requested by your insurance company to have claims processed in a timely manner.

☺Please be courteous to physicians & other patients: if needed, reschedule more than 24 hrs in advance☺

♦Appointment no-show or cancellation under 24 hrs will be charged a $35 fee ($50 for Endocrinology/ADD/ADHD/Behavioral/Special Needs appointments)♦

♦$35 will be charged per returned check♦

CASH/CHECK/DEBIT CARD/VISA/MASTERCARD/DISCOVER/AMEX/HSA ACCEPTED

CONSENT FOR CARE, ASSIGNMENT OF BENEFITS, INFORMATION RELEASE, FINANCIAL POLICY

PATIENT NAME: Last	**First**	**Middle**	**Birthdate**	**Sex: M/ F**
1.) _____			____-____-____	_____
2.) _____			____-____-____	_____
3.) _____			____-____-____	_____
4.) _____			____-____-____	_____
5.) _____			____-____-____	_____
6.) _____			____-____-____	_____

On behalf of the patient/s listed, I hereby request and consent to treatment and services reasonable by today's Standards (including recommended vaccines) provided by or under the supervision of a physician of Tae'Ni Chang-Stroman MD, PC (DBA Kids First Pediatrics on 30). I authorize payment directly to Tae'Ni Chang-Stroman MD, PC of the Medical and/or Surgical benefits for such services, otherwise payable to me. I have read and agree to the Financial Policy outlined above, and I assume responsibility for any unpaid balance including non-covered services except as limited by law. I authorize Tae'Ni Chang-Stroman MD, PC to charge the card I provide on my account as described above, & release any information to my insurance company as acquired in the course of the patient's examination or treatment. I authorize Tae'Ni Chang-Stroman MD, PC to release all medical information to specialists referred to and any agency(ies) needed to facilitate continuity of care. This authorization will remain in effect until revoked by me in writing and received by the practice manager.

I have also received/reviewed a copy of: Confidentiality of Patient Medical Records (HIPAA), and understand this is available on the practice website, and have the right to obtain a paper copy of this notice at any time.

Signature of Parent/Guardian/Responsible Party _____ **Date** _____

Social Security# _____-_____-_____ Birthdate ____/____/____

Signature of Parent/Guardian/Responsible Party _____ **Date** _____

Social Security# _____-_____-_____ **Birthdate** ____/____/____ *Signature/ Information Required in full*