Modesto Pediatrics Financial Agreement and Consent (2018)

We are committed to providing your family with the best possible pediatric care. Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

UPDATE YOUR CONTACT INFORMATION: We depend on accurate information for emergency contact and for billing. If you move, or change your telephone number please inform the front desk so we can update our data base.

BILLING YOUR INSURANCE:
- Please present your current health insurance card at each office visit.
- If you have **No Insurance** then payment in full is required at the time of service.
- Our office will bill validated insurance as a courtesy. You must pay for any patient responsibility.
- Know your insurance and **REMEMBER:** **<u>Non-covered services such as vaccines can be VERY EXPENSIVE.</u>**

PAYMENT FOR SERVICES:
- Co-pays **MUST** be paid at the time of service.
- We accept cash, checks, money orders, Visa, MasterCard and debit cards with these credit logos on them.
- We offer an Online Payment option through a secure website: www.medpayonline.com/modestopediatricsca.
- A **$9.00 billing fee** will be added monthly to any outstanding balances not paid within **30 days** of the first billing statement.

RETURNED CHECKS: The charge for a non-sufficient funds (NSF) check is $25. You must pay in full for the NSF check and NSF fee within 10 days of notice. For the next 12 months, cash or equivalent payment at the time of service is required.

COLLECTION ACCOUNTS: When an account remains unpaid after 90 days we maintain the right to refer the account to an outside collection agency. If your account is sent to a collection agency, you may be asked to find another provider.

PARENTS NOT ATTENDING APPOINTMENTS: We will need a signed note from the parent **<u>EVERY</u>** time an appointment is made giving permission for the person attending with the child/children to make medical decisions. You may complete an "annual" consent form for grandparents, caregivers, etc who will be continually accompanying your child.

SEPARATED AND DIVORCED FAMILIES: Co-pays are due at the time of service.
- Please provide us a copy of any court or mediation mandated requirements.

LATE ARRIVALS, CANCELLATIONS, AND NO SHOWS: Please be considerate.
- We require **24-hour notice** to cancel or reschedule an appointment. For appointments scheduled within 24 hours of the appointment time, **2-hour notice** is required. Failure to give proper notice for cancellation or reschedule will result in:
  - A $25.00 charge for the first missed appointment or late cancellation **($50.00 for *"Well Child"* appointments)**
  - A $50.00 charge for the second missed appointment or late cancellation **($100.00 for *"Well Child"* appointments)**
  - Potential dismissal from our practice for a third missed appointment or late cancellation

AFTER HOURS AVAILABILITY: One of our physicians or a physician in our "on-call group" will be available for urgent medical questions or concerns that cannot wait until the next business day by dialing: **(209) 550-3013**

COPIES OF MEDICAL RECORDS & OTHER FORMS: Records requests are generally fulfilled within 5 business days. If you need simple forms completed during your visit, there is generally no charge. **When the request is more involved or does not come during an office visit we charge a modest fee.**

** I acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay MODESTO PEDIATRCS directly. A copy of this authorization can be considered an original for insurance purposes.*

** I do hereby consent to and authorize the performance of all examinations, treatments, and medical services by MODESTO PEDIATRICS and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlined in this document.*

Signature: ______________________________ Date: ____________________

Print Name: ____________________________ Relationship to patient(s): ____________________

Patient(s) Name(s) and Date(s) of Birth: ____

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