Patient Name(s): _____

Date of Birth: _____

POLICIES OF BEACH PEDIATRICS

Please initial all boxes to indicate that you understand each individual policy. If you have questions, please ask us.

☐ **INSURANCE COVERAGE TERMS** — Your insurance policy is a contract agreement between you and your insurance company. You are responsible for knowing the terms and conditions of your policy. It is not the responsibility of Beach Pediatrics to know your policy details. As a courtesy, Beach Pediatrics attempts to verify eligibility and benefits, but we are unable to obtain the exact details of payment until the claim is processed.

☐ **BILLING POLICY** — We will bill your insurance company at the time of service. When the Explanation of Benefits (EOB)/insurance payment is received, your account will be credited. If coverage is denied or there is a remaining patient responsibility for any reason, you will be responsible for the payment in full when you receive a statement or at the time of your next appointment (whichever comes first). You will be billed on a monthly basis.

☐ **CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE** — Are estimated according to your policy coverage. Non-covered services for which insurance eligibility/coverage cannot be confirmed are due and payable at the time of service.

☐ **MISSED APPOINTMENTS** — As a courtesy to other patients who desire an appointment, we ask that you please give us 24 hours notice if you need to cancel your appointment for any reason. Failure to do so will result in a $25.00 fee per missed appointment.

☐ **LATE APPOINTMENTS** — If you arrive more than 15 minutes late to your appointment, that appointment may need to be rescheduled. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers whenever possible.

☐ **RETURNED CHECKS** — There will be a $35.00 returned check fee applied to your bill for any returned check. This is the charge we incur from our bank.

☐ **COPY OF MEDICAL RECORDS** — A written request along with a $25.00 fee must be received prior to release of each medical record. Please allow 2 weeks from receipt of the request and payment.

☐ **AUTHORIZATION TO TREAT MINORS** — We will be unable to treat any minor (ages 17 and under) without a parent or legal guardian consent. A minor may be treated in the presence of an adult other than the parent or legal guardian with proper written consent.

I hereby acknowledge that I have reviewed the policies above and I understand that ultimately I am responsible for payment of all charges for medical services rendered to the named patient(s). I authorize third parties to pay directly to the provider(s) any insurance benefits due for services rendered on behalf of the named patient(s).

Parent/Guardian Signature: _____ Date: _____/_____/_____

Name (Print): _____

I also acknowledge that I have reviewed a current copy of the "Notice of Privacy Policy" and understand my rights. I authorize and consent for Beach Pediatrics to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

I received a personal copy of the Notice of Privacy Policy. ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____/_____/_____

Name (Print): _____