PC PEDIATRIC CARE OF ROCKVILLE, P.A.

Financial Policy

Patient Name_____ Date of Birth_____

Your signature at the bottom is to acknowledge receipt and understanding of our policies. Refusal to sign this policy does not excuse you from being held to these rules. **Please read the following carefully.**

You must present your insurance card and any changes to your address/phone numbers at each visit in order to ensure proper billing of your claims. Failure to provide us with accurate information may result in the patient having to pay for these services. Our office will gladly file to your insurance on your behalf, and we will provide them with all necessary documentation of your visit. Pediatric Care of Rockville, P.A. is neither an agent nor an employee of any insurance company. If for any reason your insurance does not pay for services rendered by Pediatric Care of Rockville, P.A., you, the patient, are solely responsible for the balance. **You are ultimately responsible for knowing and understanding your policy, its benefits, and its exclusions and limitations.** If a balance remains unpaid prior to an appointment, the patient will be asked to pay the balance prior to being seen. Pediatric Care of Rockville, P.A. cannot submit claims relating to motor vehicle accidents to your medical insurance. Payment is required at the time of service and you will be provided with a statement to submit to your automobile insurance company. Billing statements are sent to only one address. **Newborns must be added to your insurance policy within several days of birth.**

No Show Policy: Failure to give 24 hours' notice of cancellation of any physical, preoperative or medication recheck appointments will result in a charge of $50 on the patients account. There will be a $25 charge for any same day sick appointments that are not cancelled prior to the appointment time. This charge cannot be billed to your insurance company. Failing to keep (3) appointments can result in the patient being discharged from the practice at the discretion of the practice. There will be a $25.00 processing fee for returned checks and after (2) bounced checks; you will not be allowed to write checks payable to Pediatric Care of Rockville.

Routine Exams with Additional Services: During your well child exams, there are times when additional charges may be warranted because the scope of services goes beyond what is considered routine for that well child exam. We will bill your insurance company for these charges, but additional deductibles and copays may apply.

Letters and Forms: There will be a $15 charge for any health forms to be completed and $25 charge for any letters required to be written by our providers including but not limited to special school accommodations, medical necessity, etc.

I have read and understand the policies outlined above. I understand that this list is not comprehensive and that my insurance is charged for any and all services provided deemed necessary at the time of the visit, and I agree to pay for charges my insurance does not cover. If I have any further questions, I may direct them to the office manager for further explanation.

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Patient/ Parent/ Guardian Name

_____ _____

Patient/ Parent/ Guardian Signature Date