Bethesda Pediatrics
OFFICE POLICY

Patient Name:_____ Date of Birth:_____

Welcome to Bethesda Pediatrics. It is our goal to treat you with respect and understanding in the most professional way possible. Please read the following *carefully*.

It is mandatory for us to see your insurance card and driver's license at **each** visit in order for us to be compliant with HIPAA and/or insurance regulations. We can scan and save your driver's license and insurance card for your convenience.

Our office will gladly file to your insurance on your behalf and we will provide them with all necessary documentation of your visit. Bethesda Pediatrics is neither an agent nor an employee of any insurance company. If for any reason your insurance does not pay for services rendered by Bethesda Pediatrics, 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.** Bethesda Pediatrics 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 only sent to one address.

Newborns must be added to your insurance policy **within several days of birth.**

All co-pays/outstanding balances are to be paid upon registration at *each* office visit. The caregiver (parent, relative, childcare provider) registering the patient is financially responsible for all co-pays/outstanding balance regardless of custody arrangements. Our office accepts cash, checks, Visa, and Mastercard.

Physical exam and conference appointments not canceled or rescheduled 24 hours prior to appointment will be charged a $50.00 cancellation fee. When an appointment is missed, you will receive a letter documenting the missed appointment. If three appointments are missed within a 12 month period, the patient and his/her/their siblings will be subject to dismissal from the practice. There is a $20.00 fee for each camp/activity, school, and daycare form completed as well as for letters of medical necessity. **There is a $35 returned check fee. Routing Exams with Additional Services:** During well child exams, there are times when additional charges may be warranted because the scope of services goes beyond what is considered routine. Copays and deductible may apply when these services are billed.

Consent to treat:
The following people **(OTHER THAN PARENTS)** are authorized to bring your child to our office and make medical decisions in your absence. The permission remains valid until notified in writing of any changes.
Name:_____

Relationship:_____

Name:_____
Relationship:_____

I, _____ hereby acknowledge that I have read and completely understand the above policies as stated. Any collection fees incurred for breach of this agreement will be the sole responsibility of the undersigned parent/guardian. I acknowledge the office's HIPAA policies

regarding the use and disclosure of health information and understand that I can request a copy of the policies at any time.

Parent/Guardian Signature:_____ Date:_____