

Harvest Pediatrics

Comprehensive Health Care for Infants, Children & Adolescents

PAYMENT, INSURANCE & OFFICE POLICIES

"We appreciate the opportunity to serve you and we pledge to provide our very best medical care."

Physicians & Staff of Harvest Pediatrics

PAYMENT POLICY: _____ Please initial

It is our policy to require payment of all office charges at the time they are given unless prior arrangements have been specifically made. Accounts over 30 days will be charged 1.5% per month, or 18% per annum. In the event that any balance due is not paid as agreed, the undersigned agrees to pay all costs charged by the collection company, which costs exceed 20% of said unpaid balance, including reasonable attorney fees.

INSURANCE POLICY: _____ Please initial

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will be happy to submit to most carriers if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by your insurance carrier. Please understand that as a third party we cannot be involved in prolonged insurance negotiations; this is your responsibility.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: _____ Please initial

I authorize the physician to release any medical information, including diagnoses, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my child. I understand that this medical information may be used for diagnostic/subspecialty referrals, insurance and legal purposes. I further understand that any persons receiving these medical records will not release any of the medical information obtained by this authorization to another person or organization without a further authorization signed by me for release of information.

LATE POLICY: _____ Please initial

In order for your physician to be able to provide the best care possible, it is important to be on time for your appointments. Therefore, if you are more than 10 minutes late for an appointment, please be prepared to reschedule.

IMMUNIZATION RECORDS: _____ Please initial

Please bring your immunization card with you to every scheduled well-child exam.

PRESCRIPTION REFILLS: _____ Please initial

Please allow 48 hours for all prescription refills.

NO-SHOW FEES: _____ Please initial

A \$25 no-show fee will be charged to you in the event of a missed appointment not cancelled 24 hours in advance. Three (3) no-shows will be subject to family dismissal from our practice.

Signature

Date

Please Print Name