IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY:

All services performed in our office and at the hospital will be submitted as a courtesy to your insurance. All co-pays are due at the time of service. If copays are not paid at the time of service, we reserve the right to charge a $10.00 processing fee. Deductibles and coinsurance are you responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. However, the doctor's fee may be higher than that which the insurance company reimburses or the service may not be covered. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY:

We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. ***Be prepared that you will not always be reimbursed the full amount you paid for your services by our practitioners. We will not reimburse you the difference between the reimbursement rate your insurance pays you and our fee for our services. Not all services provided by this office are a covered benefit in ALL CONTRACTS. Payment for services is DUE AT THE TIME OF SERVICE. If full payment is not made at the time of service, your appointment is subject to cancellation.

MISSED APPOINTMENT/LATE CANCELLATION:

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. For cancellations for physical exams, we require at least 24 hours notice prior to the appointment. For cancellations for sick visits, we require at least 2 hours notice prior to the appointment. Your appointment will be considered a NO SHOW APPOINTMENT if: we do not receive adequate notification of your inability to keep your scheduled appointment, you arrive more than 10 minutes late for your scheduled appointment or you do not arrive for your scheduled appointment. West Haven Pediatrics reserves the right to discharge any patient from our practice who has more than 2 No Show appointments.

HOSPITAL ADMISSION TO YALE NEW HAVEN HOSPITAL:

If your child is admitted to Yale New Haven Hospital, please be aware that during the time of admission at Yale New Haven Hospital, the Hospital physicians will be caring for your child. West Haven Pediatrics will be informed of your child's admission.

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to the practitioner. I understand that I am financially responsible for non-covered services. I also authorize the practitioner to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY WEST HAVEN PEDIATRICS. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT/GUARANTOR.

Patient Name (Please print):_____

Patient/Guarantor Signature:_____

Guarantor Name (Please print):_____Date: _____