Carolina Pediatric Group

FINANCIAL POLICY

1. All new patients must complete ALL of the patient forms in their entirety prior to being reviewed. Established patients must provide the office with any insurance changes prior to being seen.
2. Your insurance card should be available at each visit. All insurances require that we have a copy of your insurance card on file.
3. Medicaid patients are required to present their card at each visit. Those who cannot provide a card may be required to pay for the visit or reschedule.
4. Please be aware of your insurance benefits. Your insurance is a contract between you and the insurance carrier. It is your responsibility to know your insurance company's provision for payment of office visit, well-child visits, immunizations, co-payments, and deductibles.
5. Co-pays and co-insurance amounts are expected at check in, if you are unable to pay, you will be rescheduled.
6. We accept cash, checks, and Visa and Mastercard. You may also make payments by credit card over the phone.
7. Returned check fee is $25 and future payments will have to be made by cash, money order or credit card.
8. A medical record copying fee of $15 per child will be charged for all medical records requests.
9. A fee of $5 per form applies to physical forms, asthma and allergy forms, and vaccine records; FMLA forms $15 ; medical letters $10

For billing questions, please call our billing service at 1-866-258-3517.

TELEPHONE CONSUMER PROTECTION

In order for us to service your account, notify you of an appointment, or collect any amounts you owe, we may contact you by phone at any of the phone numbers associated with your account, including wireless, which could result in charges to you. Please update your phone numbers with us if any changes occur. We may also leave voice messages on these lines. If you do not want us to leave messages, please initial here_____.

NO SHOW POLICY
ACKNOWLEDGEMENT

Carolina Pediatric Group has a no-show policy. A fee of $25 will be charged for any appointment missed. After 3 missed appointments your child may be dismissed from the practice.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY, NO SHOW POLICY, AND TELEPHONE POLICY AND DO HEREBY AGREE TO THE TERMS LISTED ABOVE.

Parent /Guardian
signature_____(date)

Patient_____