Hand in Hand Pediatrics

Financial and Patient Responsibility Policy
Updated January 7, 2016

Patient Authorization: I authorize the physicians of Hand in Hand Pediatrics to provide any medical care deemed necessary according to their professional opinion. I authorize my insurance benefits to be paid directly to Hand in Hand Pediatrics. If my insurance company rejects or allows only part of the claim for services, I shall be responsible for payment of the balance due and will pay the balance within 30 days. My signature on this form verifies that I have been given the opportunity to read the Hand In Hand Financial and Patient Responsibility Policy, and that I understand and agreed to the Hand in Hand Financial and Patient Responsibility Policy.

_____ _____
Name of Patient **Date of Birth**

_____ _____
Signature of Patient or Responsible Party **Date**

HIPAA – I have reviewed a copy of the Hand In Hand Pediatrics, Inc.'s Notice of Privacy Practices.

_____ _____
Signature **Date**

Please read and initial each section below

No Show/Cancellation Policy - I understand and agree to pay the $50.00 missed appointment fee for any appointment that is not cancelled at least 2 hours in advance for same day appointments and 24 hours in advance for all other appointments. If my insurance company does not allow a no show fee then I understand that my child(ren)'s continued participation in the practice may be terminated.
Initials _____

Form Policy - I understand and agree to pay the forms fee for all forms not brought to my child's physical (well child check) appointment. I will be told the charge in advance and the form must be paid for before it may be picked up.
Initials_____

Repeat Referral Fee - I understand and agree to pay the $25.00 Repeat Referral Fee if I need to have Hand In Hand Pediatrics reschedule a referral because I did not cancel 48-72 hours in advance and Hand In Hand Pediatrics had to submit new paperwork and reschedule the referral.
Initials_____

Non-Emergent After Hours Call - I understand and agree to pay the Non-Emergent After Hours Call fee if I use the emergency line for non-emergent calls. All non emergent calls should wait until the office opens or may be left on the general message line.
Initials_____

Prescription Refill – I understand that requests for prescription refills must be called in by the parent or patient (if over 18 years of age) and that it will take 48 business hours to have the refill completed.
Initials_____

Returned Check Fee - I understand and agree to pay the $35.00 returned check fee if my check is returned unpaid by the bank.
Initials_____