Financial Policy

Acton Road Pediatrics
Where we know your child by name!

Patient Name: _____ DOB: _____

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Payment is due in full at the time of service unless you are covered by one of our contracted insurance carriers. All co-pays are due at the time of service. It is your responsibility to provide us with the correct insurance information and to be familiar with your coverage and benefits. All claims that are denied by your insurance carrier will be your responsibility.

A $25.00 charge will be assessed to your account if appointments are not kept or rescheduled 24 hours in advance. **A $15.00 charge will be assessed to your account for after hours calls.**

I understand that there will be a fee for form completion, and copies of medical records.

NON-COVERED SERVICES STATEMENT: If you have any questions about whether a particular service is covered by your insurance, or the number of services being rendered, please contact your insurance company. Depending on your health benefits contract there may be some services which may not be covered. You will be expected to pay for these services in full following notification from your insurance carrier. As your child's provider, we will only order the test(s) and treatments(s) that we feel are necessary for your child's care.

EXAMPLES OF POSSIBLE NON-COVERED SERVICES:

- **PHYSICIAN SERVICES:** Preventative care physician fee (well child visit), and vision screening. (Additional treatments: Issues addressed during a routine visit that would constitute an additional office charge.)
- **LABS:** CBC, blood draw fee, urinalysis
- **VACCINES:** Vaccines, vaccine administration
- **OTHER:** Developmental and psychological screening, any other possible non-covered services

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician and/or assistants.

This Financial Policy has been set forth as part of an overall effort to provide your child with the best possible medical care. We thank you for entrusting us with the medical care of your child. I have read this policy and agree to pay for all rendered services, including those listed above, and those that are not covered by my insurance contract for each visit my child incurs as indicated by my signature.

_____ _____

Patient/Parent/Guardian Signature Date