

## APPOINTMENT AND INSURANCE COVERAGE POLICY

### Attention Patients/Responsible Party:

**Insured Patients:** If eligibility of insurance cannot be verified, or if deductible has not been met, I understand that I will be responsible for the cost of all medical services rendered. I hereby authorize payment directly to CHANDLER PEDIATRICS for medical benefits, if any, otherwise payable to me under terms of my insurance.

**Private Pay Patients:** You are responsible for payment in full for services rendered at the time the service is rendered. If you wish to inquire about payment plans, please let office staff aware of your situation. We are happy to accept your personal check imprinted with your name, address and phone number. Also, we may require your drivers license information for check payments. Due to bank fees there will be a \$20.00 dollar charge for all returned checks.

**Please note:** There is no charge for missed office appointments. However, we urge you to let us know at least one business day prior to your appointment about any cancellation or reschedules needed. This allows the staff time to use the space on the schedule appropriately. Please do not make a habit of missing appointments! Remember, you are responsible for keeping your own appointments whether or not our office contacts you as a reminder of your scheduled date and time. After the 3rd missed appointment, we reserve the right to dismiss you from our practice for failing to comply with your physician's medical decisions.

You are responsible for any outstanding balances not covered by your insurance carrier. Insurance carriers have stated repeatedly that coverage and/or authorization is not a guarantee of payment. In the event it becomes necessary to turn your account over to an outside collection agency, you are responsible for any and all fees associated with recovery, including - but not limited to -collection agency fees, attorney fees and court fees.

Chandler Pediatrics reserve the right to deny service to any person who fails to comply with the above information.

\_\_\_\_\_  
Print Responsible Party Name

\_\_\_\_\_  
Responsible Party Social Security #

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Today's Date