



**FINANCIAL &  
GENERAL POLICY STATEMENTS**

**Insurance Cards**

It is your responsibility to provide us a copy of your child’s insurance information each time you come to the office. If your insurance requires designation of a Primary Care Physician (PCP), please ensure that we are listed as PCP prior to your appointment.

We will submit claims to your insurance but you will be responsible for any charges not covered by your insurance. Please try to be aware of what your insurance covers.

**Payment options**

For your convenience, we accept cash, checks or credit cards.

Copayments are due at the time of service and you are responsible for knowing your copay amount.

For patients with high deductible plans, payment is required within 30 days of the visit.

**Patient Statements**

Outstanding balances are due within 30 days. If you are unable to pay the balance in full, please contact our billing department to discuss payment options.

A \$10 statement fee will be added to accounts with balances more than 60 days past due

A \$30 fee will be charged for any returned checks in addition to any bank fees incurred.

I have read and fully understand this financial policy. I understand that MiKids Pediatrics has the right to amend this policy at any time without prior notification.

I authorize payment of medical benefits by the insured directly to MiKids Pediatrics, PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or material provided to my family member and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment is negotiable in advance. I authorize MiKids Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

**Cancellations, late, and missed appointments**

We understand that there may be times when you need to miss or reschedule an appointment. If you are unable to make an appointment, we ask that you give us at least 24 hours notice so that we can make that slot available for another patient. If you fail to call and cancel your appointment, it will be registered as a “no show”. 2 or more “no shows” per family may result in a \$25 fee and your family may be asked to discontinue service with our practice. If you are more than 10 minutes late for your appointment, you may be asked to reschedule your appointment.

**Medication Refills**

Please allow 2 full weekdays to process your child’s medication refills. We want to make sure that your prescription is handled properly and verified by the appropriate physician. When you call and leave a message on our prescription line, please verify dosage, frequency, pharmacy, and whether you would like a 30 or 90 day prescription. (You may want to check with your insurance on whether they cover 90 day prescriptions as this can be a cost and time savings.)

Medications prescribed for chronic conditions including asthma, ADHD, anxiety and depression, along with certain other conditions will require a visit every 6 months (1 of which can be a well check) to make sure we are monitoring, advising and prescribing appropriately.

Patient names (Please list all children) \_\_\_\_\_  
\_\_\_\_\_

Name of parent or guardian \_\_\_\_\_

Signature of parent of guardian \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_