NEW HORIZON PEDIATRICS, P.C.

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FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship.
We believe that advising you in advance of our office policies allows us for a good flow of communications. **PLEASE READ THIS CAREFULLY AND INITIAL.**
If you have any questions, please do not hesitate to ask a member of our staff.
Thank you for choosing New Horizon Pediatrics.

FINANCIAL RESPONSIBILITY CONSENT & ASSIGNMENT OF BENEFITS

I, hereby accept that I am financially responsible for all services rendered on my child or children's behalf By New Horizon Pediatrics, P.C. For those insurances from which the Practice accepts assignment, I accept responsibility for all co-payments, deductibles, and non-covered services, as indicated by my insurance company. I certify that the information I have reported regarding my insurance coverage is correct. I authorize payment directly to the practice for services for which the Practice accepts assignment.

Initial: _____

MEDICAL RECORDS

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations, and such other purposes that are permitted under the Federal Health Insurance Portability and Accountability Act (HIPPA) without written consent.

Initial: _____

INSURANCE COVERAGE

According to your insurance plan, it is your responsibility to understand your benefit plan. You are responsible to provide our office with all required information regarding your health insurance coverage. If the insurance company you designate is incorrect, you will be responsible for all unpaid balances. If our physician(s) do not participate in your insurance plan, payment in full is expected from you at the time of your office visits. In addition, it is your responsibility to determine from your insurance carrier what co-payments and deductibles are due. Co-payments are due at the time of service.

Initial: _____

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service, payable by cash, credit card, or check. Dishonored or returned checks will incur a $35.00 service fee.

Initial: _____

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorney's office. If your account is referred to a collection agency, you will be responsible for paying a collection charge of up to 50% of your outstanding balances, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balances and any applicable interest.

Initial: _____

MISSED APPOINTMENTS

If you miss a scheduled appointment or cancel the appointment late-less than 24 hours of the appointment time- a $50.00 fee will be billed to you and this fee is not covered by insurance. If you miss a scheduled well-baby/child appointment or cancel the appointment less than 48 hours of the appointment time a $75.00 fee will be billed to you and this fee is not covered by insurance. Additionally, if you have two concurrent, no-shows/late cancellations, your physician reserves the right to dismiss you from the practice.

Initial: _____

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPPA or other controlling laws (or under other circumstances as required by law). In accordance with Virginia law, we charge a $10.00 research fee and postage and photocopy fee of 50 cents per page for up to 50 pages.

Initial: _____

By signing below, the patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

_____	_____
Patient (s) Name (s)	**Date**
_____	_____
Print Name of Responsible Party	**Relationship to Patient**
_____	_____
Signature of Responsible Party	**Date**