PALMETTO PEDIATRICS OF THE LOWCOUNTRY
"NO SHOW" POLICY

Our office has adopted a 24 hour cancellation policy for scheduled appointments. If you are unable to keep your child's appointment but do not cancel, this appointment will be counted as a "No Show". If a child(ren) have multiple "No Show" appointments, they may be dismissed from our practice.

STATEMENT OF FINANCIAL POLICY

It is our firm belief that all of our patients deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies.

If we are participating providers in your plan, we will accept assignment for payment and submit a claim on your behalf to the insurance company. We require a copy of your current health insurance card in order to submit a claim. You must provide our office with accurate insurance information in order for us to file your claim. Failure to provide accurate information may forfeit your right for us to file your claim. Some insurances require you to satisfy an office copay and/or deductible before they submit payment. We require co-pays and/or deductibles be paid at the time services are rendered. It is important to remember that your insurance coverage is a contract between you and your insurance company. You are responsible for any balances or charges not covered by your insurance. The Guarantor will receive patient statements unless our office has been notified differently.

If your insurance requires referral approval for a specialist, it is your responsibility to notify us, so that, we may have the necessary documentation available. Refer to your insurance policy.

If you receive a patient statement, please remember you have already received services from our office and the balance is your responsibility. If you are unable to pay your balance in full, please contact our billing department to make payment arrangements. Accounts over 120 days may be sent to a collection agency and patient released from the practice.

Acknowledgement of HIPAA Notice

I hereby acknowledge that I have been given an opportunity to review the privacy practices of Palmetto Pediatrics of the Lowcountry, LLC. I understand that I may obtain a copy of the Notice of Privacy Practices.

I hereby acknowledge that I give Palmetto Pediatrics of the Lowcountry, LLC consent to electronically check prior medication history and to prescribe medications electronically to the pharmacy.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I, the undersigned, authorize payment of medical benefits to Palmetto Pediatrics of the Lowcountry, LLC for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Palmetto Pediatrics of the Lowcountry, LLC to release to my insurance company, referring physician and other consultants on my behalf information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

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Signature of Responsible Party Date