Children's Choice Pediatrics

~Where Medicine and Compassion Meet~

Providing Healthcare for Infants, Children, and Adolescents

Patient Name_____

Date of Birth_____

To Our Parents,

_____Please bring your insurance card and photo identification for every visit. It is your responsibility to make sure that the PCP listed is one of our physicians. ***If you do not have your insurance card and/or we are unable to verify insurance, you will be responsible for payment or you may have to reschedule the appointment.***

_____I understand that I may receive a separate bill if my medical care includes labs, x-rays, other diagnostic services and/or treatments that may be done at the time of my visit. I further understand that I am financially responsible for any co-pay or balances due for these services whether insured or a self pay patient. **Please note, if you have a secondary insurance you must call each company and coordinate your benefits. Medicaid insurance is ALWAYS secondary to any other health plan.**

_____If your child is a newborn, it is your responsibility to add your child to your insurance within 21* days of birth for the child to be covered. ***If you have not added your child to your policy and/or we are unable to verify coverage, partial payment /payment arrangements will be due at the time of service.*** CHIPS* Perinatal, your child must be added immediately for coverage to be effective. If this is not done by time of service, we will be glad to reschedule the appointment or make payment arrangements for the visit.

_____We make every effort to see you in a timely basis. ***If you are 15 minutes late, in consideration of those arriving on time, you will be asked to reschedule your appointment.***
Please allow 72 hours for all prescription refills. Please allow 3 business days for all forms to be completed.

_____We do make confirmation calls for every patient on our schedule so always make sure you advise us in advance of any changes in phone numbers, address and insurance.

_____All "No Show" appointments or appointments that are not cancelled without 24 hours advance notice will be assessed a $35 fee. If any patient has 3 or more "No Show" appointments they will be dismissed from our practice.

_____ _____

Signature Date