North Florida Pediatric Associates

Patient Billing & Financial Policy

As a courtesy, North Florida Pediatric Associates will file a claim for all services to your insurance company. Therefore, at registration, you will be asked for your insurance information. It is your responsibility to ensure we have your most current insurance information and to notify us of any changes.

It is also your responsibility as the guarantor to verify that North Florida Pediatric Associates is a **participating provider with your insurance company** and to be familiar with your plan benefits (i.e., deductibles, copayments, in and out of network costs).

To summarize, you will be responsible for **payments at time of service** for the following reasons:

- Your insurance company requires you to pay deductibles.
- Co-payments are required by your insurance company.

You will be responsible for a bill for the following reasons if:

- The service is not a covered benefit.
- Co- insurance is required by your insurance company.

Payments are due at the time of service; you are expected to make payment in full. We accept cash, check, American Express, MasterCard, Visa and Discover.

The parent/ Guardian or authorized individual that brings the child to an appointment is responsible for payment at the time of services rendered.

Missed Appointment/ No- Show Policy

An appointment is considered a **NO- SHOW** if:

- **The patient has not arrived within 15 minutes of the scheduled appointment time.**
- **We do not receive a 24- hour notice for cancellation of all appointments other than same day scheduled appointments.**

Patients who miss or no- show for a double well appointment (bringing two children at the same time) will be restricted from scheduling double well appointments in the future. _____ **(Initial)**

Patients who miss or no- show for a first well (new patient) appointment, your family will no longer be eligible to establish care at North Florida Pediatric Associates. _____ **(Initial)**

If you no- show 3 appointments within a calendar year, we reserve the right to dismiss your family from the practice. _____ **(Initial)**

If you miss or no- show an appointment, you will be charged a **$25.00** No- Show fee. _____**(Initial)**

_____ _____

Patient Name Signature of parent/ guardian

_____ _____

Print Name/ Relationship to Parent Date