

Office Policies:

- All copayments and deductibles are due at the time of service.
- There will be a \$25 fee for missed appointments, or appointments that are not cancelled with at least 24 hours notice. This fee is not covered by your insurance company and will be billed directly to you.
- If you arrive more than 15 minutes late for your appointment, it may be necessary to reschedule your appointment. This is up to the discretion of the physician.
- There will be a fee of \$17 for walk-in appointments. This fee will be collected at the time of service in addition to any copayments or deductibles that may be due.
- There is a fee of \$10 for completing any camp or school form. This fee is not filed to your insurance Company and is must be paid before the form is released. This does not include immunization forms (3231/3300 forms), for which we provide at no charge. Please allow 3-5 business days for completion of all forms.

Insurance coverage is not a guarantee of payment. Pediatric Associates, PC follows the recommendations of the American Academy of Pediatrics and Bright Futures. It is your responsibility to know what is covered under your insurance plan, as all procedures we offer may or may not be covered by your insurance. You have the right decline any procedure recommended by the physicians of Pediatric Associates, PC. It is your responsibility to pay any copayment, co-insurance, deductible or other balance not paid by your insurance. If this account is assigned to an attorney and/or collection agency for collection, you will be responsible for any attorney/collection fees.

For the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Including Medicare, private insurance and other health plans to: Pediatric Associates, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Please sign below that you have been offered an opportunity to review a copy of our HIPPA notice of Privacy practices. You are entitled to a personal copy of our privacy policy to keep for your records if you so choose. If you have any questions about our policy, please contact the Privacy Officer at (770) 993-2922.

Signature of parent or patient (if over 18)

Date

3000 Johnson Ferry Road, Suite 204 Marietta, Georgia 30062