CARROLL CHILDREN'S CENTER

FINANCIAL RESPONSIBILITY & OFFICE POLICY
(Please read carefully)

Standard of Care:

We follow the American Academy of Pediatrics (AAP) and Maryland Healthy Children guidelines including immunizations, growth and development, risk assessments and screenings, etc. We expect you to comply with these guidelines as well as any health related guidelines from your insurance company.

Appointments:

We kindly ask that you give no less than 24 hours notice when cancelling an appointment. Missed appointments may result in fees:

* Routine appointments (well/physical exams, sports physicals, behavioral health visits, consults, medication checks) that are missed, as well as those that are not cancelled without 24 hours notice before the appointment time (2 hours for sick appointments) may result in a **$25 fee**. If there are three or more "no show" appointments within a one year period you may be asked to transfer care to another practice.

* If you are late for your appointment (>20 minutes), we will do our best to accommodate you. However, on certain days it may not be possible and it may be necessary to reschedule your appointment.

Initial: ________

Permission for Medical Care:

All children under the age of 18 must be accompanied by an adult. Any adult who is not the patient's legal guardian must have written permission to authorize medical treatment for the child. Patients who are 18 or older will be given the option to sign a release allowing our office to discuss their care with whomever they choose. By law, we are not permitted to disclose medical information pertaining to any patient aged 18 or older to their parents unless the patient has given us written permission to do so.

Initial: ________

Referrals:

The need for written referrals varies by insurance carrier. Should you require a referral to see a specialist you must first schedule your appointment with the specialist before a referral can be issued. We ask that you allow a minimum of 48 hours to complete your referral. Please be prepared to provide us with the specialist's name, address, telephone and fax numbers, reason for visit and date of appointment. You may call the office and choose the option for a referral and leave the information after the recording.

Initial: ________

School, Sports, Camp, Daycare Forms:

Because of the increasing demand, complexity, and length of time it takes to complete them, it is very important that you bring your form to us as soon as it is received. Parents should complete their portion of the form in advance. The patient must have an up-to-date (within the past 12 months/6 months for sports forms) physical exam on file with our office. There is a $5 fee for standard processing of a form (48-72 hours). The fee for a "stat" processing of a form is $10 (within 24 hours or same day).

Initial: ________

Financial Responsibility:

At the present time, ___________________________is my insurance carrier. I will inform Carroll Children's Center (CCC) of any changes with the above insurance carrier. I certify that I am not enrolled in any Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) that is not contracted with Carroll Children's Center.

As a courtesy, Carroll Children's Center has agreed to file a claim for services rendered with my insurance carrier. I am responsible and expected to pay Carroll Children's Center for the following:

1. Any co-payment as set by my insurance carrier. A $5 billing fee will be assessed for any co-payment not paid at the time of service.
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier
5. Any charge/fee established by Carroll Children's Center for forms, missed co-pays, and missed appointments.

Initial: _______

If Carroll Children's Center has not received payment from my insurance carrier within 60 days from the date of service, I may be expected to pay my balance in full. I am responsible to be sure that all charges are paid, whether by me or my insurance carrier, as my insurance policy is a contract between me/my employer and the insurance company. CCC is not a party to that contract. *Please be aware that some and perhaps all of the services provided may be considered non-covered or not reasonable and customary charges under your medical plan, and may become your responsibility*. Further, the adult accompanying a minor and/or the parents (or guardians) of the minor are responsible for payment.

Initial: ________

Patients Without Insurance: Payment in full is due at the time of each service. If you are unable to pay the entire balance at the time of service, you will be required to pay a $50 deposit and sign a Promissory Note making arrangements for a payment plan. The $50 deposit does not cover the office visit for that day; it only covers a portion of the charges. Additional Services may be billed after the visit based on diagnostic tests completed during visit deemed necessary by the physician.

Initial: ________

I understand that payment is required at the time services are rendered unless other arrangements have been made with the Billing Department in advance. Carroll Children's Center accepts cash, personal checks, VISA, MasterCard, Discover and American Express. *There is a service charge for returned checks for any reason for the fee charged to us by our bank. And further, the office reserves the right not to accept future checks if any checks have been returned previously.*

I understand that I may be subject to a **"Late Fee"** of $10.00 per month if my account balance is not paid within 30 days of receipt of my first statement. Carroll Children's Center reserves the right to charge this fee on unpaid patient balances at the rate currently allowed under Maryland law.

Regardless of insurance coverage, if after default, my account is placed in the hands of an attorney or collection agency for collection, I agree to pay a service charge of 25% of the unpaid balance and all attorney and/or collection fees, together with all additional costs and expenses of collection to the present extent of the law.

Initial: ________

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO COMPLY AND ACCEPT THE RESPONSIBILITY FOR ANY PAYMENT THAT BECOMES DUE AS OUTLINED IN THIS DOCUMENT.

Patient Names—please list all children that are patients of Carroll Children's Center:

Patient Name:______________________________ **Date of Birth:__________________________**

Patient Name:______________________________ **Date of Birth:__________________________**

Patient Name:______________________________ **Date of Birth:__________________________**

Patient Name:______________________________ **Date of Birth:__________________________**

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Patient's Name (Please Print) **Patient's Signature/Date (if 18> years old)**

As Parent/Guardian of the above referenced individual, I will continue to be responsible for all cost incurred for the services rendered up to the age of 18.

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Parent/Legal Guardian (Please Print) **Parent/Legal Guardian Signature/Date (Seal)**