Please initial:

_____ Per our contract with your insurance company, co-payment and co-insurance amounts are due and must be collected at the time of service. Co-payment and co-insurance amounts not paid at the time of your appointment may result in an additional charge of $10.00 to cover our cost of billing you for the balance.

_____ We request that you notify us 24 hours in advance should you be unable to make your scheduled appointment, so that we have a sufficient amount of time to accommodate other patients. For appointments made the same day, we request a minimum of 2 hours advance notice. Failure to provide advance notice may result in a $25.00 "No Show" fee for each appointment missed. Multiple missed appointments may result in the family being dismissed from the practice. *Valid emergencies are excluded.*

_____ In order to minimize waiting time, we request that patients and their parents arrive for their appointments on time. If you are more than 10 minutes late for your appointment time, you may be asked to reschedule. *Valid emergencies are excluded.*

_____ We will bill your **primary** insurance company for services provided. Once insurance has processed the claim we will bill you for charges that they have deemed your responsibility. Account balances over 90 days past due are subject to a 20% APR monthly compounded interest charge.

_____ As the subscriber, you are responsible for knowing the terms, limitations, referral and pre-authorization requirements of your specific insurance plan. Castle Rock Pediatrics is not responsible for charges incurred as a result of any particular service not being covered and/or paid for by your plan, nor can the staff of Castle Rock Pediatrics be responsible for knowing the terms of your policy. You are responsible for any visit, treatment, and/or equipment charged for and not covered under your plan.

Date: _____

Patient Name(s): _____

Parent Signature: _____
Revised 10/31/14