OFFICE POLICIES

CROSSROADS PEDIATRICS

PATIENT RESPONSIBILITY

The patient is required to pay all co-payments/co-insurance amounts at the time of service. If Crossroads Pediatrics is contracted with your insurance company, we will bill them for you and make every effort to ensure that claims are promptly and correctly processed. If payment has not been recieved from your insurance company within 60 days, Crossroads Pediatrics will request payments in full from you, because you are ultimately responsible for any unpaid balances.

PAYMENT IN FULL

Full payment is required at the time of service from all patients that have a co-payment, have not met their deductible, or that do not have insurance.

RETURNED CHECKS

Checks returned for insufficient funds will be subject to a $25.00 fee.

PAST DUE BALANCES

If you have a previous account in collection status, payment in full is required before any further service is rendered.

PATIENT AUTHORIZATION

I authorize Crossroads Pediatrics to release any medical information necessary to process insurance claims relating to the medical care rendered by Crossroads Pediatrics.

I authorize payment of medical benefits to Crossroads Pediatrics for any medical care rendered to my dependents. I understand that I am responsible for any amount not covered by my insurance.

By signing below, I acknowledge that I have read and agree to comply with the policies of Crossroads Pediatrics.

MEDICAL RELEASE

I give my consent for the doctor of Crossroads Pediatrics to do a complete and thorough examination on the patient named above. To the best of my knowledge, the information that I have given is correct. Furthermore, I understand that it is my responsibility to inform Crossroads Pediatrics of any future changes to my child's medical status. As the parent or legal guardian of the patient named above, I do hereby grant Dr. Edward Madrid and his staff permission to perform any needed treatment. I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

FINANCIAL AND INSURANCE INFORMATION

Please remember to bring your insurance card to all visits. We are dedicated to providing all our patients with the best treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or doesn't pay. Please note the following in regards to your medical insurance coverage:

We must emphasize that as a health care provider, our relationship is with you and not your insurance company. We will be happy to file for your insurance benefits, though we are not obligated to do so. Prior to your visit, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out of pocket portion. Please remember, this is only an estimate based upon generalized information provided by your policy. An additional billing or possibly a refund may be subsequently required should these estimates be inaccurate. Any amount not covered by your insurance company is payable at the time services are rendered despite what your insurance card may state; these fees may include deductibles, co-payments, or certain procedures not covered by your insurance policy.

Requirement for Filing Insurance Claims

To expedite the filing of my medical insurance claims, I do hereby authorize the release of confidential information to my medical insurance company and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (45) days of treatment. I hereby authorize payment of insurance and government benefits directly to Crossroads Pediatrics for services rendered. After attempts to collect outstanding funds and a 90-day grace period from time of service, parents/guardians not fulfilling their financial obligation will be sent to

collections, as stipulated by our accountants. Furthermore, in the event of payment default for services rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this balance.

Custody/Divorce Agreement

As an advocate for our young patients, Crossroads Pediatrics will not intervene in any court custody dispute or financial responsibility dispute between parents or other responsible parties. We will not bill the other parent or split the charges for the other parent responsible. It is your responsibility to coordinate and provide payment at the time of service.

Cancellation Policy

In an effort to provide all our patients with timely care, we ask that you have the courtesy to honor our 24-hour cancellation policy. This, in turn, will allow us to provide treatment for another patient in great need. We reserve the right to charge patients a $25.00 No show fee for any appointment broken without 24 hour prior notification.

Other Fees

Crossroads Pediatrics reserves the right to charge the following fees:

Medical Records: $5.00

School/Sports/Camp/Daycare: $5.00

FMLA Paperwork: $25.00

Prescription refill without office visit: $20.00