Shifa Pediatric Clinic, PLLC

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Date: _____

1. Co-payments must be paid at time of service. If this payment is not made, you will have to reschedule your appointment.
2. Insurance information must be provided to our office at every appointment. It is up to the patient to ensure our staff has the most current insurance information/identification card on file. If your claim is denied for incorrect insurance information you will be responsible for the entire cost of this visit.
3, Self-pay patients: new patients must pay $75.00 prior to seeing the physician. Any amount charged over this $75.00 can be paid at time of check out or can be billed. Established patients must pay $60.00 prior to seeing the physician. Any amount charged over this $60.00 can be paid at time of check out or can be billed.
4. Unless cancelled at least 24 hours in advance, a missed .appointment fee of $10.00 will be charged to your account. This fee must be paid before another appointment can be made with our office. Our policy is to confirm all scheduled appointments 24-48 hours prior to your appointment. It is up to the patient to confirm our office has correct contact telephone numbers upon scheduling. If we have an incorrect contact number you will still be liable for this fee.
5. Non-covered services are the responsibility of the patient. These include deductibles/ co-insurance/ copayments and services excluded by your insurance company. It is the patient's responsibility to know what is or is not covered by their insurance policy. All insurance policies are unique therefore we cannot verify all benefits before treatment.
6. Completion of forms/letters is subject to a $20.00 fee which must be paid prior to release of these documents. These forms include, but are not limited to: disability forms, FMLA forms, motorized wheelchair forms, Dmv forms, and letters to employers.
7. Returned check fees are $25.00. If a check is returned to our office for insufficient funds a check in the form of payment will no longer be accepted. Future payments must be paid by cash, money order or credit card.
8. Medical records will be provided to the patient upon completion of a release of medical records form. A fee of $25.00 must be paid prior to delivery of these records. Please note: we do not charge a records fee to other medical facilities or insurance companies.
9. Our office does not bill automobile insurance carriers or workman compensation carriers. The patient must pay $ 100.00 prior to seeing the physician and the remaining balance upon check out. However, if you have medical health insurance coverage we will bill automobile accident claims to those carriers.
10. Past due account balances will be turned over to a collection agency. Just as we make every effort to accommodate you when you are in need of physician care, we expect that you will pay your bill promptly. If you have a hardship or are unable to pay your bill promptly, please contact our billing department to discuss payment options. Failure to do so will result in your account going to collections and we will ask that you seek medical care from another medical practice.
11. If one of our physicians refers you to seek treatment from a specialist, it is your responsibility to schedule that appointment. You will need to contact your insurance company to obtain a list of specialists that are participating with your insurance. Once scheduled you must provide written notice to our office of this scheduled appointment.
12. We require 48 to 72 hour notice for prescription refills. We cannot guarantee a refill will be issued in less than 48 hours therefore do not wait until your prescription has run out to seek a refill.

I, the undersigned, have read and fully understand the financial policies of Shifa Pediatric Clinic PLLC and agree to accept responsibility as described.

Patient name signature _____