STAMFORD HEALTH
Healing. Reimagined.

Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

We appreciate our selection of our practice for your children's medical care. To prevent any possible future misunderstanding, we have prepared the following summary of our financial policies.

We will require a copy of your insurance card and billing information. Please bring the card with you to each visit. If you join or change plans, please inform us immediately. If you fail to inform us of any changes in coverage, you will be responsible for payment for services rendered. We will balance bill you per your insurance plan.

It is our policy that the person bringing the child to our office is responsible for payment at the time of the visit for services rendered, regardless of which parent has the ultimate legal obligation to pay for medical care. It is the parents'; sole responsibility to settle these financial matters between themselves and caregivers.

FEES FOR SERVICE:

- **MISSED APPOINTMENT FEE** – For physical appointments not cancelled 24 hrs. in advance = $75. After 2 "No Shows" the fee increases to $100 per visit. After 3 "No Shows" you may be asked to leave the practice.
- **TELEPHONE CONSULTS** – After hours calls to our "Pediatric Triage" Center, between 9pm & 8am, will be directly billed to you, $20/each.
- **COPY OF MEDICAL RECORDS** – After the medical release form is completed, our office will send it to the Stamford Health HIM department to be processed.
- **VFC/STATE VACCINES** – Available for those who qualify, $21/administration fee/dose.
- **RETURNED CHECK FEE** – Is $25.

MEDICAL FORMS POLICY

Effective 1/1/2014. There will be a $10 fee per form per child. This includes school, camp, medication, allergy protocols, etc., whether sent in or brought in at the time of a visit. Forms mailed in still require a one week turn-around time and an enclosed check, along with a self-addressed stamped envelope. We will continue to offer our "Urgent Form" option for all forms that need to be completed within 48 hours or less for a $30 fee per form.

Responsible Party's Statement, Authorization and Assignment of Benefits:

- A photocopy of this authorization shall be considered as effective and valid as the original.
- I authorize the release of any medical information necessary to process claims.
- I authorize payment directly to The Pediatric Center for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse The Pediatric Center for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments, charges not covered under my insurance benefits and the above fees for service.

I agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered.

Children's' Names:_____ Date:_____

Signature: _____ Relationship to Patient(s):_____

Home#:_____Mother's Cell#:_____Father's Cell#_____

E-Mail:_____