TENTH STREET PEDIATRIC MEDICAL GROUP, INC. CARE FOR INFANTS, CHILDREN AND ADOLESCENTS

Financial Policy

Thank you for choosing Tenth Street Pediatrics as your child's health care provider. The following is a copy of our financial policy. Patient care is not permitted without the written consent of the receipt and acknowledgement of the understanding of this policy.

Payments: Payment, in full, is due at the time of service. This includes applicable co-pays, co-insurance, and payments for services not covered or denied by the insurance company. Tenth Street Pediatrics accepts cash, personal check, debit cards, and credit cards. _____ (initials)

Self-Pay Accounts: If you do not have insurance please come prepared to pay for your visit in full upon checkout. _____ (initials)

Missed Appointments: Missed appointments represent a cost to us, you, and to other patients that could have been seen during the time set aside for your child. Cancellations are required 24 hours prior to any well visit appointment and two hours prior to any sick visit appointment via phone call to the practice. A "no show" fee of $50 will be applied if an appointment is missed and not cancelled within the stated time frame. _____ (initials)

Outstanding Balances: If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of statement or within 30 calendar days. _____ (initials)

Payment Plans: Tenth Street Pediatrics understands that full payment may not be possible in certain circumstances. As a courtesy, Tenth Street Pediatrics may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our management team. Patients with a payment plan must be in full compliance with all conditions of the agreement at time of visit. Payment plans require a credit card on file to be automatically billed according to the agreement. Failure to make scheduled payments on the payment plan, or not paying off a balance in full may result in your account being turned over to a collection agency and you family dismissed from the practice. _____ (initials)

Returned Checks: A $30 fee will be charged for any checks returned for insufficient funds. _____ (initials)

Caryn B. Cassidy, M.D. • Marcella B. Hardart, M.D.
Lisa C. Stern, M.D. • Carla V. Tardio, M.D. • Jeffery L. Wasson, M.D.

1450 10th Street Suite 304 Santa Monica, CA 90401-2838 Tel: (310) 458-1714 Fax: (310) 394-8754 www.tenthstpeds.com

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Insurance: Tenth Street Pediatrics is currently contracted with many (but NOT all) PPO plans for Anthem Blue Cross, Blue Shield, Cigna, Aetna, and United Healthcare insurance (this does not include POS, EPOS, EOS, or HMO plans). For all non-contracted PPO plans, payment in full is due at the time of each visit. We will bill your insurance company directly for you as a courtesy. Please contact your insurance company to verify we are listed as a contracted provider and what services are covered by your insurance plan before scheduling an appointment. All non-covered services will be billed to the account holder. _____ (initials)

Administrative Fee: Tenth Street Pediatrics charges a yearly administrative fee. This fee reimburses us for all "non-covered" services such as extended hours on weeknights, longer appointment times for check ups, completing school/sports/camp forms, all phone calls including reviewing lab results over the phone, on-call access to one of our board certified pediatricians 24/7, phone follow-up after visits when needed AND keeping our office open 365 days a year, including all weekends and holidays This fee will be due each calendar year and varies based on age and number of children from your family that are being seen by our practice. _____ (initials)

Change of Insurance/Change of Account Information: Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes the assigned account holder becomes responsible for any and all charges. _____ (initials)

Billing Inquiries: Questions about a bill should be directed to our billing department at 310.458.1714.

Review and consent of this policy is required prior to services rendered.

Patient's first name: _____ Last name: _____ DOB: _____

My initials above and signature below certifies that I have read and consent to the outlined policies and procedures.

_____ _____ Date: _____

Signature of parent/guardian **Printed name of parent/guardian**

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