

Carrollton Pediatrics

Payment Policy

4300 N. Josey Ln., Suite 110
Carrollton, TX. 75010

Office: (214) 483-3292

Fax: (214) 483-3286

Welcome! Please read the following office policies and let us know if you have any questions.

1. If you do not have insurance coverage, payment is expected at the time of service. The cost of a new patient visit is \$75.00 plus the cost of shots or any other procedures required. If you do not have a method of payment available or if you are unable to afford this minimum, please let us know prior to your visit. We do not retro bill for self pay visits in case you get insurance with retroactive dates. However, we will gladly provide you with a copy of superbills and your receipt.
2. Please sign in at the front desk with receptionist. Please complete the paperwork in its entirety.
3. Please pay your co-payment when you check in. If you do not have your co-payment, we will ask that you reschedule your appointment. We do not accept checks.
4. Please have your driver's license, shot record and insurance card ready. We must have a copy of your current insurance card. If you do not have a valid insurance card, we will hold you responsible for the full amount of the visit.
5. We ask that you please contact our office with any address, telephone, or insurance changes.
6. As a courtesy to all our patients, you may be asked to reschedule your appointment if you are more than 15 minutes late. Please call us 24 hours in advance to cancel or reschedule an appointment. After 3 NO SHOWS or failure to cancel within the 24 hour notice you will be asked to change doctors.
7. Your insurance company may require additional information to process your claim such as accident details, coordination of benefits or student status. Your insurance company will request this information in writing. It is very important that you provide your insurance company with the information to process your claims. You are allowed 10 days to get this information to your insurance company. If, after 10 days, your insurance company has not received this information from you, the balance will become your responsibility and you will receive a statement from us for payment in full.
8. After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. We will send you a statement. The balance is due within 30 days.
9. If your insurance company mistakenly sends you our payment, please forward the check immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.
10. If you need a prescription refilled, contact your pharmacist. Please allow 24 hours for all prescription refills. If you lose a prescription or a shot record there will be a \$5.00 fee.
11. There is a \$10.00 returned check fee. In the event of a returned check, please contact our office immediately.
12. There is a \$5.00 charge per page for forms that need to be filled
13. In case we do not accept your insurance or we are not the PCP, the patient will be responsible for the bill. Payment will be due at the time of visit. Please confirm with our front office personnel regarding insurance acceptance.
14. Medical records transferred to patients and/or guardians will be charged a \$15.00 charge fee.

I, _____, do hereby affirm that I have read and understand the above policies. I hereby assign Carrollton Pediatrics all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment directly to my treating physician for medical services rendered to me or my dependents regardless of my insurance benefits, if any. I authorize Carrollton Pediatrics to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I give permission to Carrollton Pediatrics and its staff to treat and provide services needed to the patient. I understand that I am responsible for all medical fees during my treatment with Carrollton Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Parent/ Guardian Date