SALUD PEDIATRICS | PARENT AGREEMENT

The parent agreement outlines a series of requirements that parents or legal guardians must commitment and consent to for their children to become patients of Salud Pediatrics. The agreement includes office and financial policies.

PLEASE READ IT CAREFULLY. AND IF THERE ARE ANY QUESTIONS, PLEASE DON'T HESITATE TO ASK.

INSURANCE PLANS

I understand it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen under "out of network" benefits.

INSURANCE BENEFITS

I acknowledge that Salud Pediatrics is not responsible for knowing what services my insurance covers. I shall direct questions regarding health insurance policy coverage to my insurance company.

COPAYMENTS | DEDUCTIBLES | COINSURANCE

I agree to be responsible for all copays, deductibles, coinsurance and any other non-covered services determined by my insurance plan at the time of my visit. If I've not come prepared to pay for balances or have made arrangements with the billing staff, my child's appointment may be rescheduled.

DESIGNATED GUARANTOR

Salud Pediatrics does not accept a child's parent or legal guardian to designate another parent or legal guardian as the person responsible for financial obligations with the practice.

FINANCIAL RESPONSIBILITY

I understand that the adult that brings a child to the visit is responsible for paying copayments or any past due balances, whether the adult is the parent, a legal guardian or parent representative.

DEMOGRAPHIC VERIFICATION

I am aware that I will be asked to verify insurance and demographic information, so records remain current.

VACCINE POLICY

Salud Pediatrics adheres to the CDC's & the AAP vaccination schedule. The practice does not accept patient whose parents refuse to vaccinate their children according to AAP & CDC recommended vaccination schedule.

PROOF OF INSURANCE

If insurance benefits cannot be determined, I understand that payment is required in full at the time of service. In some circumstances, I may have the option to put a credit card or debit card on hold until proof of insurance is determined.

CREDIT CARD ON FILE

I authorize Salud Pediatrics to keep my credit card on file (See CCOF Agreement for details).

PATIENT RESPONSIBILITY PAYMENTS

I authorize Salud Pediatrics to automatically process the card on file for any amount that my insurance plan deems patient responsibility.

EMAIL NOTIFICATION REGARDING PATIENT RESPONSIBILITY BALANCES

Salud Pediatrics will send a notification to the email on file regarding the patient responsibility amount that will be processed. The email notification we arrive 5-days before the credit card on file is processed.

STATEMENTS & PATIENT PORTAL

I understand that Salud Pediatrics will not mail a statement when there is a patient balance. Statements are available on Salud's free patient portal.

DELINQUENT ACCOUNTS

Patients with past due accounts with the practice (with no payment arrangements made) will be discharged from the practice regardless of the past due amount.

RETURNED CHECKS

I understand my account will be charged $25 for NSF/Returned checks.

FORMS FEES

I understand Salud Pediatrics charges for forms that are not requested at the time of my visit. I'm also aware that for letters on company letterhead, the practice will charge a per letter fee according to the Form Fee policy.

LATE ARRIVALS

If I arrive more than 20 minutes past my scheduled appointment time, my child's appointment may have to be rescheduled.

NO SHOWS

I commit to giving Salud Pediatrics at least 24 hours notice if I am unable to keep my scheduled appointment. Salud Pediatrics does not charge for no-shows; however, if I miss 3-appointments without notifying the practice in a 12 month period, the practice will no longer be able to continue providing health care services, and I understand I will be dismissed from the practice.

MINORS

If my child is not accompanied by a legal guardian, written authorization must be provided before health services can be rendered. I also agree to be available by telephone in the event that the physician needs to contact me.

I have read the parent agreement. I have clear expectations of what the practice requires of me as a parent. In addition to providing consent, I understand that Non-compliance with this policy may result in a dismissal of Salud Pediatrics.

Sibling Name _____

Sibling Name _____

Sibling Name _____

Parent Name _____

Date:

Salud
PEDIATRICS