Financial and Office Policy

Estrella Pediatrics, P.C.
623-388-3216
623-388-4902

9305 W Thomas Rd
Ste 125 & 575
Phoenix, AZ 85037

Patient Last name	First:	DOB:	M/F

Please take the time to review the following policies and procedures, initial each one and sign where indicated.

Consent: The patient's legal representative consents to the treatment and services which may be performed during this and any future visits, and which may include but are not limited to laboratory procedures, examinations, treatments or procedures.

Delegate: We require that a legal guardian accompany a minor patient unless prior written authorization is given to this office. The adult accompanying the minor is required to pay in accordance with our policies.

Divorce: We do NOT recognize or enforce the terms of divorce decrees nor accept third party assignments of any kind.

Lateness: If you are unable to arrive for your appointment on time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled or work you in behind other scheduled appointments.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing if you want to have copies of your records sent to another doctor or organization. There is a reasonable copying fee of $10 if requesting for your personal records. You authorize us to include all relevant information, including your payment history.

Contracted Insurance: You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. It is the insurance company that makes the final determination of your eligibility.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. If you are unable to pay at the time of service, there is an additional charge of $10.00 for each copay billed.

Deductible Plans: All deductible plan patients will be required to pay a $50 deposit for each applicable visit per child. Office visit costs may increase based upon the visit complexity, labs done in office, and treatments given. If the cost of the visit is more than the deposit amount, a statement will be sent. You may also choose to sign the easy pay consent form on the back in lieu of paying the visit up front.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, there will be a $25 surcharge fee imposed on your account and you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all of the lawyer's fees which we incur plus all our court costs. In case of suit, you agree the venue shall be in Phoenix, Arizona.

SEE BACK SIDE→→→

Missed appointment fee: Patients who do not show up for a scheduled appointment, or cancel with less than 24 hours' notice will be charged a $25 fee.

Returned checks: There is a fee (currently $25) for any checks returned by the bank. NSF checks must be redeemed with certified funds (money order, certified check, or cash) for all future payments.

Visits: The provider is required to code the visit based on all care provided and if an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive exam, and/if the abnormality/problem is significant enough to require additional work (either during the visit or after), then separate billing for a problem visit may occur. With this in mind, while the appointment may have been scheduled for just a preventative exam or just for a problem(s), if both types of services are provided during the exam then both types of services may be billed. We cannot change the coding after it has been submitted to your insurance company in order for them to pay non-covered services.

Third Party Vendors: Cost for any labs, diagnostic testing, durable medical equipment or treatments done outside of our office are patient's responsibility. These costs are not associated with Estrella Pediatrics. This includes labs that are sent out from our office to the laboratory or durable medical equipment provided in our office on behalf of the vendor. These services are billed to your insurance directly by the third party.
*If Estrella Pediatrics provides durable medical equipment in the office, it is not included in the visit. Please check with your insurance company to verify your benefits and coverage prior to accepting. The durable medical equipment company will bill your insurance directly and Estrella Pediatrics is not responsible for any costs incurred.

Information about Deductible Plans

The average cost for a typical visit for a patient with a deductible plan is $100. We require a $50 deposit from all patients that carry a deductible with their insurance plan. If you are unable to pay this amount upfront, we will require a credit card on file, to be able to charge the balance once the insurance processes the claim. Office visit costs may increase based upon the visit complexity, labs done in office, and treatments given. If the cost of the visit is more than the deposit amount, a statement will be sent.

PATIENT EASY PAY CONSENT FORM

I authorize Estrella Pediatrics, P.C. to charge my payment card for the balance of fees determined as member responsibility by my insurance carrier:

□ All visits from ____/____/_____ to ____/____/_____ (90 day minimum), not to exceed a charge of $100 per child, per visit.
□ Indefinitely, not to exceed $100 charge per child, per visit.

If the cost of the visit is more than $100, a statement will be sent for the remaining balance.

I choose to have a receipt: □ mailed to the address on file
□ emailed to the following address: _____

_____ _____
Card Holder Name Card Holder Signature

_____ _____ _____
Credit Card Number Card Expiration Date CVV (3 or 4 digits)

By signing this form, I am acknowledging having read each statement, having had the opportunity to ask questions and agree to honor the above policy. I understand that discharge from the practice may result if this agreement is not abided by.

✍_____ _____
Parent/Guardian Signature Relationship

✍_____ _____
Printed Name Date

We look forward to establishing a long and wonderful relationship.