PEDIATRIC ASSOCIATES

43 Batavia City Centre, Suite A
Batavia, NY 14020
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21 Main St
Attica, NY 14011
(585) 708-4008

Fax (585) 343-3783

Child's Name: _____

Office Financial Policy

Updated 3/17/2006 to reflect HIPPA guidelines.

Our financial policy has been set up to prevent any misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

1. I understand that co-pays are expected at the time services are rendered.
   a $10.00 fee will be incurred for each patient statement generated for unpaid copays.
2. I agree that I have listed Dr. Muhammad S. Idrees or Dr Nashiha Shahihd listed as my child's PCP on their health insurance coverage. In the event that one of the doctors listed above is not listed as my child's PCP, I agree to be responsible for payment.
3. I authorize Pediatric Associates to bill my insurance company and receive payment on my behalf. I will be responsible for any co-pay or balance due after my insurance has made payment.
4. I understand that there is a $30.00 service charge for returned checks.
5. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my child's medical records, if necessary.
6. I agree that if I do not pay my balance due after 90 days from the date of service rendered my account will be sent to a collection agency.
7. I agree to pay all attorney fees and collection costs in the event of default of payment of my charges.
8. If I cannot keep an appointment, I must notify this office at least 24 hours in advance. In the event that I miss an appointment I understand there will be a $5.00 missed appointment fee and $10.00 for missed physical appointment.
9. In the even that I decide to transfer my child to another physician's office I understand there is a $10.00 fee for transferring each child's records.
10. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature of Parent _____ Print Name _____

Date _____