Developmental Pediatric Specialists

PROMOTING CHILD DEVELOPMENT AND SUCCESS

Developmental Pediatric Specialists, Inc.
Financial Policy

Thank you for choosing us. We are committed to your satisfaction with our services. The following is a statement of our Financial Policy, which we require you read and sign prior to any services.

Developmental Pediatric Specialists does not file (bill) or accept assignment from any private insurance carrier or Medicaid. Full payment is required for all services at the time that the services are rendered. **We accept cash, checks, and all major credit cards .** We will be happy to provide you with the forms you will need in order to file the claims from your child's visit yourself to your insurance carrier for any possible reimbursement. Please note our providers are **out of network with all private insurance companies as well as Medicaid and Medicare**. This means that your visits, when filed to your insurance, will go towards your out of network benefits. It is your responsibility as a patient/guarantor to obtain any authorizations or referrals that may be needed for your visits.

Appointments

We request 48 hours advance notice for rescheduling appointments or cancellations of your appointments, if you fail to comply with this policy **you may be charged a fee of 50%** of the cost of your visit for loss of time for our providers, a cost that will go towards the balance of your rescheduled appointment . If you "no-show" for two appointments, we reserve the right to discontinue scheduling any future appointments. Appointments are limited and there may be a long wait if you choose to reschedule an appointment at the last minute. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below you are acknowledging that you have read, understand and agree to this Financial Policy.

_____

(Patient's Full Name and Date of Birth)

_____

(Print Name of Client or Person Financially Responsible for this Bill)

_____

(Signature of Client or Person Financially Responsible for this Bill)

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