DOLPHIN PEDIATRICS, LLC
9850 STIRLING ROAD, SUITE 103
COOPER CITY, FL 33024
TEL (954) 362-3200 - FAX (954) 362-3205

FINANCIAL POLICY

Thank you for choosing Dolphin Pediatrics as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. COPAYMENTS ARE DUE PRIOR TO THE VISIT AND DEDUCTIBLES WILL BE COLLECTED THE SAME DAY AFTER THE VISIT. We accept: Cash, Check, Visa, MasterCard, Discover and American Express (Credit card payments must be over $10.00)

PROOF OF INSURANCE: All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance information. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. We are In Network with most major insurance carriers. However, it is the patient's responsibility to verify that we are participating providers of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurance, and deductibles must be paid at the time of service. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from us, your primary care physician if your insurance carrier requires it for your visits. Please allow 48-72 hours for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a $35.00 fee for missed appointments (no show). Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: Please be aware that some, and/or perhaps all, of the services you receive may not be covered, or not considered reasonable or necessary by Medicaid or other insurers. You will be responsible for payment of these services, in full, at the time of visit.

RETURNED CHECKS: Any checks returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice), along with a $25.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collecting agency fees, court cost, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

There is a flat fee of $10.00 for each set of school and sports clearance forms the office completes on your behalf.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patients Name: _____ Date: _____

_____

SIGNATURE OF PARENT/GUARDIAN and PATIENT IF 18+

REV 08/09/2018