VALLEY PEDIATRIC MEDICAL GROUP FINANCIAL POLICY

Welcome to Valley Pediatric Medical Group! We are glad you have chosen us as your child's pediatrician and we strive to give your children the best in medical care. We understand that in addition to needing to feel comfortable with your child's physician, many parents have concerns about the financial policies of the practice. This information is designed to answer frequently asked questions.

- Valley Pediatric Medical Group is contracted with most PPO insurance plans.
- Please bring your insurance card with you at each visit. Notify the office if your insurance has changed.
- As a courtesy to you, we will file your child's insurance claim for you.
- All co-payments, co-insurance, deductible, etc. must be paid at the time of service.
- It is your responsibility to know your insurance benefits.
- Any services provided to a parent, grandparent, or any adult are collected in full at the time of service. We will not bill your insurance, but will provide you with a form suitable for filing with your insurance.
- To avoid a $50.00 no-show fee, it is required that you cancel appointments 24 hours in advance.
- We charge $25.00 to copy medical records
- Valley Pediatric Medical Group is happy to complete any camp/school forms if your child has had a physical in the last 12 months. Non urgent forms will be completed within 3-5 business days and are $5.00 to complete. Urgent forms can be completed on the same day for $15.00.
- If during a well-child physical a diagnosis is identified that requires further management and treatment, there will be an additional fee for the service.
- We do perform certain lab test in our office. If your pediatrician orders a lab test that is not done in our office, you will receive a separate bill from the lab chosen.

For your convenience, we accept cash, check, and all major credit cards. Our business office staff will be happy to answer any question that you have, please call 818-788-1716. Non-compliance with this policy may result in transfer of care to another practice. I understand and agree to the above financial policy.

Date______________________

Signature of responsible parent____________________________

Child/Children's name____________________________________