

Acknowledgement Of Receipt Of Notice Privacy Practices

I have received a copy of this office’s Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this form if requested.

Patient Name _____ DOB _____
Parent Name _____ Signature _____ Date _____

Notice of Office Policies

At Acorn Pediatrics of San Antonio we will make every effort to file insurance claims on your behalf. Copays, deductibles, and coinsurance along with outstanding balances are due at the time of service. Any remaining balance due after your health plan pays is due upon receipt. Account balances over 90 days may be sent to a collection agency.

Your insurance policy is a contract between you and your insurer. Do not assume your policy covers all services at 100%. We can’t quote your benefits. Any items deemed “not covered” will be your responsibility. This includes lab work and other outside providers.

We request you please keep us up to date on address and phone numbers so we can better serve you.

We are not party to legal disputes. Financial responsibility for a visit rests with the adult presenting with the patient or the patient if over 18.

A \$35 fee will be assessed for all returned checks - that amount may be higher if higher bank fees are incurred.

A \$50 no show fee per patient will be charged for physical and ADHD evaluation appointments not cancelled 24 hours prior.

Payments are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service. Refunds over \$50 will be provided within 30 days of all outstanding claims being satisfied. Credit balances less than that will be processed at the patient’s request.

I have read the above and been allowed to ask any questions.

Signature _____ Date _____