# ACD Pediatric Group

## OUR POLICY

Please read carefully the following policy and write your initials on the line at the side of each statement.

_____ Appointments are to be re-scheduled/cancelled 24 hours prior, not the same day and not on the afternoon. NO EXEPTIONS.

_____ For laboratories – We are NOT to discuss your test results over the phone, you will need to make an appointment. For any results that require immediate attention, the patient will be contacted immediately.

_____ Any copayment that is required for any patient, is to be paid at the time you arrive for your visit. NO EXEPTIONS. Please be aware that some insurance plans require co-insurance or deductible that is the responsibility of the patient to pay.

_____ If any patient does not fully provide specific information regarding your insurance coverage, the patient is fully responsible for the office visit.

_____ Non-coverage from your insurance, for any service provided in this office, is the Patient's responsibility.

**Thank you for your cooperation.**

Patient Name: ______________________________ DOB: ____________

Parent/Guardian: ___________________________ Signature: _____________

Date: ___________________

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