



Financial and Telemedicine Policies: (*Please initial*)

- I understand that initial intake appointments are completed via Telemedicine and are considered your first appointment with Baker Pediatrics, LLC. These are billed appointments to your insurance and co-pays are due for the appointment.
- I understand that all co-payments are due on date of service.
- I understand that missed appointments (if not cancelled 2 hours prior) will have a charge of \$40.00.
- I understand that missed well appointments (if not canceled 24 hours prior) will have a charge of \$75.00.
- I understand that returned checks will have a charge of \$30.00.
- Our contracts with insurance companies require that we verify your current coverage and co-payment on each visit. Insurance cards should be presented at every appointment.
- I understand that appointments made for immunizations only (including Flu) are considered regular appointments and are billed as such per each individual.
- I understand that I am responsible for co-pays prior to Telemedicine appointments. Payments can be made online or by calling the office.
- I understand that Telemedicine appointments will occur through the telephone.
- I understand that the laws that protect privacy of medical information and the confidentiality of medical information including HIPPA, all apply to telemedicine.
- I am consenting to receive health care services via telemedicine.

_____ I understand that every insurance agency has a different policy regarding what services it will cover and how they “classify” each visit. Once a service is provided, if your insurance company classifies it as a non-covered service or put the charges to your deductible, you will be responsible for payment of these services.

_____ I understand that for divorced/split families-the parent bringing the child in for care is responsible for the cop-payment. Both parents are responsible for payment on unpaid balances. If payment issues exist, they must be resolved between the parents.

Baker Pediatrics, LLC offers the option to keep a credit card or HSA card securely on file for co-pays, balances and the annual CAP fee. With enrollment in this program, receipts for co-payments and coinsurance will be automatically emailed to the address you provide.

_____ I would like to enroll. *(Please complete Payment Authorization Form)*

_____ I would like to decline from enrollment.

I have read and understand the financial policy of Baker Pediatrics, LLC and I agree to be bound by its terms. I understand and agree that such terms will remain in force for the duration of my relationship with Baker Pediatrics, LLC.

Signature

Printed Name

Date

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