CHILDREN'S HEALTH CARE CENTER OF NORTHERN VIRGINIA
A NOTICE TO OUR PATIENTS REGARDING OUR OFFICE POLICY

In an attempt to keep our patients informed and to insure proper reimbursement for services rendered, we ask that you carefully read the following instructions. By working closely together toward this goal we can provide you with better care and avoid confusion in the future with regard to your charges.
We currently participate with a number of health plans. This does change periodically. Therefore, you may wish to inquire as to our participation with your particular plan. By signing the necessary forms at the time of your registration we can file your insurance claims for you. Please be aware that as medical providers, our relationship is with you and not your insurance company. Problems relating to your coverage should be handled between you and your carrier.

It is the patient's responsibility to be informed as to what your insurance plan will and will not cover. **For most insurances, there is no co-pay for a Well Child visit. However, if your child presents with an illness there may be a Sick visit billed in conjunction with the Well Child visit. We will bill both to your insurance, but depending upon your policy you may receive a bill for a copay and-or coinsurance from the additional Sick visit.** We cannot adjust charges or diagnosis codes after services are rendered.
Co-pays are due at the time of your visit per your insurance. It is cost prohibitive to bill for these accounts. There may also be a fee if you must be billed for your co-pay. If your insurance carrier denies payment, it is our policy that these amounts are to be paid within 90 days. We will bill you for charges allowed, but not paid, by your insurance plan. There is a $30.00 returned check fee.
You are responsible for providing credible and legal proof of insurance. It is the policy of the practice to consider you self-pay if you do not have insurance coverage. Charges are due in full at the time services are rendered. Failure to present applicable insurance card(s), including those that require Children's Health Care Center of Northern VA, P.C., or Bryan McEachern, MD to be listed as the primary care physician, or a referral for services will be considered as self-pay.
Repeated mailing of statements is costly and will continue to become more costly as postage rates increase. Because of this, if we do not receive payment or a response from you on invoices over 90 days old, these accounts will be forwarded to the collections attorney for further collection efforts. Charges associated with these actions will be the responsibility of the patient.

We ask for 24 hours notice for cancellations. **IT IS YOUR RESPONSIBILITY TO NOTIFY THE OFFICE WHEN YOU ARE UNABLE TO KEEP YOUR APPOINTMENTS!!!** We charge a $40.00 NO SHOW fee for appointments not kept and notification not given. This is not reimbursable by your insurance.
Please allow 5 business days for referrals. We have a large volume of incoming requests for referrals and they are completed on a first come, first serve basis. **Please do not arrive at another physicians' office without a referral, as we will not be able to accommodate these requests without notice. Last but not least, because of the volume of paperwork associated with managed care, our office must charge for form completion and custom letters. There will be no charge for the first form/letter requested per patient/per year. All forms requested after that, per patient, will be at $5 each. All forms require 48-72 hours to complete.**
MEDICAL RELEASE OF INFORMATION: There is a **$30.00** charge per medical record for records to be released. We also ask for up to 5 days to make copies of the medical records, it is your responsibility to notify us in a timely manner of the need to release the records. Same day requests will not be guaranteed!!!!

We are aware that insurance matters have become more confusing with the passage of time. We regret this and appreciate your cooperation. Signature of this form indicates that the HIPPA policy was made available to you. This form is valid for 1 year from the date signed.

_____ _____ _____
Patients Name/s Parent/Guardian Signature Date

Please see reverse side