

Financial Policy

General Consent

I the parent of _____, authorize Dr. Marina Yam to provide diagnostic and preventative services to my child deemed as necessary for their health

This authorization shall remain effective while patient is under Dr. Yam Pediatrics care.

Parent / Legal Guardian: _____ Signature: _____
Date: _____

Credit and Financial Policy

_____ You are financially responsible for all charges incurred at the office. Certain insurance plans do not cover particular charges including (but not limited to) well care visits, vaccines and lab procedures. Please be familiar with your particular coverage and/or plan, as it is the your responsibility to pay for services not covered by insurance.

_____ We will bill your primary insurance (and secondary insurance, if applicable) as a courtesy (provided we are given correct billing information). It is the patient's responsibility to follow up on all discrepancies.

Remember that you, and not your insurance carrier, are ultimately responsible for payment for all the services rendered in our office for your child. If your insurance carrier does not pay within 60 days, our office shall expect payment in full from you.

_____ The billing statement you receive will specify any outstanding patient balance, in addition to insurance correspondences and/or payments. Payment for patient balances is due upon your receipt of the statement.

_____ Payment for services rendered is due and payable at the time you receive services. Co-payments are required at the time of service and if proof of insurance is not provided, payment in full will be required at the time of service. (We will promptly refund the patient as soon as the payment from your insurance has been received and processed by our billing office).

Charges will be assessed for the following:

Missed Appointment:	\$40
Returned Check:	\$25 + returned check amount
Minimum Late Charge (for any outstanding balance >30 days):	\$25 /per month
Co-payment not paid at the time of the visit:	additional \$10 processing fee
Copies of Medical records:	\$20 / per record
Forms required by schools, etc. (if not presented at the time of the visit)	\$10 / each

The undersigned hereby acknowledges to have read and agree to the above financial credit and payment policies of Marina Yam M.D. Professional Corporation.

Signed: _____ Date: _____

Parent / Legal Guardian: _____ Patient Name: _____