Marina Yam M.D. Professional Corporation
825 Pollard Road Suite #109, Los Gatos, CA 95032

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

Please inital the underlines.

_____ You are financially responsible for all charges incurred at the office. Certain insurance plans do not cover particular charges. Please be familiar with your coverage and/or plan, as it is your responsibility to pay for services not covered by the insurance.
_____ We will bill primary insurance as a courtesy. 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.
_____ Copayments are required at the time of service. If copay is not received within a 48 hr period there will be an additional charge. If you have not met your deductible, you will have to pay at the time of the visit. (We will promptly refund you 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 (24hr cancellation notice required)	$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 $20 late copay fee
Copies of Medical records:	$40/ per record
Forms required by schools, etc.	$10/ each

Please Note: We DO NOT accept credit cards.

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

Date: ____________ Patient Name: __________________

Parent/ Legal Guardian: _______________________ Signed: ____________________