PEDIATRIC ENDOCRINE ASSOCIATES
1100 LAKE HEARN DRIVE, SUITE 350
ATLANTA, GEORGIA 30342
TEL: 404-255-0015 FAX: 404-845-3080

CURENT FEES

150.00- NEW PATIENT MISSED APPOINTMENT
65.00- DATA INTERPERTATION FEE
50.00- NO SHOW FEE
50.00- LATE FEE
25.00- SURCHARGE IF COPAY NOT PAID
25.00- LOST FEE - PRESCRIPTION/LAB/X-RAY
15.00- REFILE INSURACE FEE
15.00- SCHOOL/CAMP FORM FEE
25.00- INCORRECT INSURANCE FEE
10.00- SATELLITE CONVENIENCE FEE
(April 2009)
5.00 - HAZ MAT FEE

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FINANCIAL POLICY

IF I DO NOT SPEAK ENGLISH, IT IS MY RESPONSIBILITY TO OBAIN AN INTERPERTER TO ASSIST IN COMPLETING AND UNDERSTANDING THESE DOCUMENTS.

SE NO HABLO ESPANOL ES UN RESPONSABILDAD LLENAR TODAS FORMAS ANTES EN CITA.

We are committed to providing your child with the best medical service available. Your clear understanding of our Financial Policy is important to us. **Please read carefully.**

WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, AMERICAN EXPRESS

ALL INSURED PATIENTS

-To prevent fraud, Federal & insurance regulations require that we confirm the identity of out patients. You will be asked to provide a photo ID along with your insurance card during your first visit. Please provide your insurance card at each visit.
-PEA allows 60 days from the date a claim is filed for my insurance plan to pay.
-As a patient it is my responsibility to know and understand my insurance plan. This includes my financial responsibility for services rendered such as co-pay, deductibles, co-insurances and anything else that my insurance plan determines is my responsibility.
- It is my responsibility to provide PEA with any information necessary to process my claim. Any information requested by my insurance is necessary for processing. If I do not provide the requested information I will be billed for the balance.

-**BY LAW DEDUCTIBLES/CO-PAYS CANNOT BE WAVED**.

-I am responsible for any services and/or procedures not covered by my insurance plan. If I am seen **without** a referral I am responsible for the charges. It is also my responsibility to ensure my insurance plan pays my bill in a timely manner. If no payment has been received after the 60 day grace period I will be billed for the balance.
-PEA expects payment of my account in full within 30 days. If I cannot pay the entire balance, a payment plan can be arranged by calling the PEA business office. 404-255-0015.

UNINSURED PATIENTS

- If I do not have insurance, I am expected to pay for services rendered in advance unless prior arrangements are made.

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APPOINTMENT POLICY

- I understand all appointments must be cancelled 24 hours prior to appointment date and time. Failure to give a full 24 hours notice will result in a missed appointment fee. New patients will be charged 150.00 all established patients will be charged 50.00. **NO EXCEPTIONS** will be made. Please call **404-255-0015 X166** to access our 24 hour cancellation line to avoid missed appointment fees.

- I understand by missing 2 appointments within a 6 month period OR 2 consecutive appointments my result in my child's dismissal from PEA.

- I understand that all fees must be paid prior to my child's next appointment in order for my child to be seen on his/her next visit. If fees are not paid at the time of my child's next appointment I understand I will be rescheduled and a 50.00 missed appointment fee will be billed to my child's account for that day.

-I understand that my child will be rescheduled if they arrive late for his/her appointment and a 50.00 late fee will be charged to my account for that day.

- I understand that my child will be rescheduled if I fail to bring his/her blood sugar monitor AND at least 7 days of hand written logs with me to **EVERY** scheduled appointment for my child. (Faxing your logs is permitted, however you must bring your original hand written copy to each scheduled appointment) A 50.00 missed appointment fee will be billed to my account for that day if I am rescheduled.

I (patient name) ______________________________understand the above and acknowledge that I may be charged for the above mentioned fees if applicable.

Patient Siganture: _____________________________________Date:________________

Parent/Guardian Signature: ______________________________Date:________________