200 Liberty Avenue
Lafayette, LA 70508
PH: (337) 989-8080 FAX #: (337) 981-0913

To help us run our office in a Reasonable and Timely Manner, we ask that you consider the following rules that are being enforced:

LATE: If you are late for your appointment (15 minutes or more), we will do our best to accommodate you. However, on certain days, it may be necessary to reschedule your appointment. If you continue to be late more than 3 times, you may be asked to find another physician to care for your child. _____ (initial)

NO SHOWS: We ask that you please call our office to cancel or reschedule at least 24 hours before your appointments. If you have 3 or more NO SHOW appointments, you may be asked to find another physician to care for you child. _____ (initial)

FINANCIAL POLICY: All payments are due at the TIME of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines" and if we are not provided with accurate information at the time of service, you may be responsible for the payment in full for services rendered. Please keep in mind that your insurance is a contract between you and the insurance company. Not all insurances cover all procedures. This is impossible for us to keep track of, however we will do our best to help you. Please contact your insurance company to determine if our doctors have a contract with your insurance company. Any financial portion that is the "members responsibility" such as co-pay, deductible, co-insurance or non-covered will be collected at the time of service. If your child comes alone for their appointment, he/she must bring payment with them. *WE MUST SEE YOUR INSURANCE CARD & DRIVER'S LICENSE AT EVERY VISIT*!!!! _____(initial)

SIBLINGS WITHOUT APPOINTMENTS: We respectfully ask that you refrain from asking the doctor to examine a sibling that does not have an appointment. This prevents the doctors to properly document the visit in the medical record, as well as prevents them from being on time for their next patients. We ask that you call us ahead of time to add sibling to an appointment. _____(initial)

DIVORCE DECREE: We are not part of your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult. _____(intital)

PAYMENTS: We accept cash, debit, Visa, MasterCard, Discover & HSA cards and personal checks. Any outstanding balances are due within 30 days of the statement. If you experience circumstances beyond your control, please contact our billing office to make arrangements. Even if you call your insurance company

because you feel there is an error, we need to know to keep your account out of collections. If no payments made within 90 days (3 months) will be sent to in house collections and no future appointments will be made for the patient until paid in full. _____(initial)

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $25.00 in addition to the original amount of the check. After 2 returned checks, we will no longer be accepting checks from you. If you do not respond to our call or statement due to a returned check within 30 days, then we will no longer be accepting checks from you weather it's the first one or the second check. _____(initial)

TERMINATION FROM OUR PRACTICE: We value our patient relationships and want to protect patient's rights. We will terminate after careful consideration for reason of: too many no show appointments, not complying with our medical care, being hostile or abusive to ANY staff member or not paying your bills. _____(initial)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physicians at Sola Pediatrics, LLC rendering services to release to my insurers, billing and certain medical information including final diagnosis and operative procedure(s) relative to this or related hospital/office claim for the purpose of determining eligibility for coverage and payment of charges for services rendered in connection with their care. I also give permission for the physicians associated with Sola Pediatrics, LLC to treat my child to the best of their ability and to release my medical information to another physician assisting in my healthcare. _____(initial)

AUTHORIZATION TO LEAVE MESSAGES ON VOICEMAIL/ANSWERING MACHINES

Under state law, the doctors with Sola Pediatrics, LLC are not permitted to leave specific medical information on voicemail without your explicit consent. I understand that signing this form allows the doctors with Sola Pediatrics, LLC to leave voicemails on the phone numbers listed below with details such as patient's name, laboratory results, request for follow-up appointments, information about referrals, or any other pertinent information no specifically listed.

- I understand this authorization is not mandatory or required.
- I understand that if I wish to rescind this authorization, I must do so in a written form and address it to the office manager of Sola Pediatrics, LLC.

_____ yes, please leave a message on one of the following phone numbers:

( )_____. ( )_____. ( )_____.

_____ No, don't leave any specific messages.

_____ _____

Signature of Parent/Legal Guardian Date