A New Day In Pediatrics

**Child and Adolescent Health Specialists, PC**

**DEVELOPMENTAL-BEHAVIORAL PEDIATRICS**

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## CANCELLATION and PAYMENT POLICY

**Child's Name:** _____ **Date of Birth:**_____

Due to the considerable time involved with Developmental Appointments, our office has developed the following Cancellation and Payment Policy:

**Consultation and Testing appointments** require **5 days**' notice during regular business hours, or a charge of **$300.00** will be applied**.**

**Follow Up appointments require *48* hours' notice during regular business hours will incur a $150 charge.**

*Calls for cancellations must be received during regular business hours Monday-Friday.*
*Calls will not be accepted by the afterhours emergency answering service for cancellations.*
*Monday appointments must be cancelled by 5pm the preceding Friday.*

An active credit card number is required to be kept on file with our PCI compliant secure gateway, to which we will bill all outstanding balances which may include deductible, copayment/coinsurance, appointments missed or cancelled without required notice, insurance denials for non-covered services, partial payment, no referral or inactive insurance.

Your signature below indicates that you authorize Child and Adolescent Health Specialists, PC to charge your credit card for patient balances as listed above. A receipt will be sent to you once your payment has been processed.

Credit Card to reserve your appointment time: Type: (circle one) MasterCard or Visa

Name on Card: _____

Credit Card #: _____

Expiration Date: _____

CV # (3 letter code on back): _____

**Cardholder's SIGNATURE:** _____ **Date**: _____