A New Day In Pediatrics

Child and Adolescent Health Specialists, PC

PAYMENT and CANCELLATION POLICY

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

In order to meet the demand for appointments and respect the time given to all our patients, our office has developed the following Cancellation and Payment Policy:

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

Follow-up appointments with a Developmental-Behavioral Pediatrician and Therapy appointment cancellations require ***48*** **hours'** notice during regular business hours or a **$150 charge** will be incurred.

Cancellation of General Pediatric appointments:
Behavioral Health Appointments (eg anxiety, depression, ADHD) require ***48*** **hours' notice during regular business hours to avoid a $75 charge.**
Well visits or recheck/follow up appointments require 24 hours notice to avoid a $75 fee.
Immunization appointments require 24 hours notice to avoid a $15 fee.

If patients arrive late for an appointment, we will fit you in *if it is possible*. If our schedule does not allow for this, you must reschedule. You will be offered our next available appointment.

Reminder: A parent or legal guardian must accompany patients under 18 years of age.
Calls for cancellations must be received during regular business hours Monday-Friday.
Calls will NOT be accepted by the afterhours answering service for cancellations.
Monday appointments must be cancelled by 5pm the preceding Friday. Reminder calls are a courtesy. We do not schedule appointments without your agreement. While we understand things happen, it is your responsibility for keeping your appointment.

CHILDREN ON MEDICATION WILL NOT RECEIVE REFILLS IF APPOINTMENTS ARE NOT KEPT.

Frequent cancellations/missed appointments impact the care we can provide to our patients and are a burden on our staff. Patients who cancel frequently or no show 3 times over a 12 month period, will be asked to seek care elsewhere.

An active credit card number is required to be kept on file with our secure gateway, to which we will bill ***all outstanding balances*** which may include: insurance deductibles, copayment/coinsurance, appointments missed or cancelled without required notice, insurance denials for non-covered services, partial payment, lack of referral or inactive insurance. A fee of $25 will be applied to declined cards.

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 upon request once your payment has been processed.

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

223 Chief Justice Cushing Hwy., Ste. 201, Cohasset, MA 02025 ♦ T. 781.383.8380 ♦ F. 781-383-8382
www.childhealthspecialists.com