OFFICE POLICY
ROSENTHAL PEDIATRICS AND ADOLESCENT MEDICINE

OFFICE POLICY ON PAYMENT:
It is our policy to require payment of all office charges including co-pays, deductibles and non-covered services at the time of the visit. In the event any balance due is not paid as agreed, the undersigned agrees to pay all costs charged by a collection agency.

INSURANCE POLICY:
Insurance provides for reimbursement on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers and addresses. **You are responsible for all deductibles and charges not covered by insurance**. It is your responsibility to notify our office when you have a change of insurance by presenting you new insurance card information at the time of your visit.

MISSED APPOINTMENT CHARGES:
In order to provide the best possible service and availability to our patients, it is our policy to charge $25.00 for any missed appointment not cancelled at least 24 hours prior to the scheduled appointment time.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my child. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my child's behalf.

I have read the above and accept financial responsibility in full for this account.
Signed:_____ **Date:**_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name:_____ **Relationship:**_____

Phone # _____