Desert Willow Pediatrics
Joy Peskin M.D., F.A.A.P

FINANCIAL POLICY

Desert Willow Pediatrics is dedicated to providing excellent care and understanding overall-service to every patient at every visit. In the interest of avoiding misunderstandings that may arise due to any financial matters, please take note of our financial policy.

Our office participates with most major health plans, but please remember:

- It is your responsibility to verify that Joy Peskin, M.D. is a participating health care provider in your health plan. This should be done prior to making an appointment.
- It is your responsibility to know your benefits and to understand that if services rendered are applied to your deductible or considered non-covered services; you will be responsible for payment.
- Co-pays and any balances on accounts are due at the time of service.
- Insurance cards must be brought to each visit so that we can ensure that we are billing the most current insurance plan.
- In the event your bank returns a check payment to our office as unpaid, a $35 fee will be assessed to the account.

CANCELLATION/NO SHOW POLICY

- We ask that every patient arrives **15 minutes** prior to their scheduled appointment to allow time for the check-in process. If you miss your appointment, we may have to reschedule you to accommodate all the other patients on the schedule. It is your responsibility to contact the office if running late or need to cancel.
- DWP strives to accommodate as many same day appointments as possible in order to provide the best possible care to all our patients. Therefore, if you need to cancel an appointment, please provide a 24 hour notice so we can offer the time to another patient. If sufficient notice is not provided, you could be considered a **"no show"** and may be charged a **$35 to $50 fee**.
- Repeat violators of these policies could be dismissed from our practice.

HIPPA ACKNOWLEDGEMENT

I acknowledge that I understand my HIPPA rights and how they will be used to carry out treatment. I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Policy Practices for Desert Willow Pediatrics.

By signing this form, I acknowledge that I have read and understood all the above policies.

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Responsible Party Signature **Date**

***This acknowledgement will be scanned into the patient's permanent EHR.** ***Rev 9/2018**