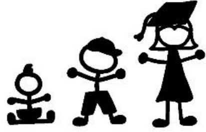

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Andrea Wolf, M.D.

Financial Responsibility Policy

Date:____________________

Patient Name(s): ____

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Practice Name: Inwood Village Pediatrics

As positive verification of my medical coverage may or may not have been verified at the time of service, I agree to pay for all medical services provided by Inwood Village Pediatric physicians and ancillary providers. I understand I may be subject to additional charges for any treatment not covered in the scope of my scheduled appointment. Subject to include 24-hour cancellation fees; no show fees; vaccinations; laboratory fees- including blood draws, strep test, flu test, covid test, Iscreen test, and surveys (postpartum and ASQ), after hour calls/text, prescriptions and/or any procedures not listed, etc. I understand and agree to the financial responsibility of this practice should my insurance company deny charges for my care.

In the event payment is not rendered at the time of service, I agree to pay for all services provided upon receiving a written and/or verbal notice of the denial of my claim. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record.

By my signature, I certify to having read the above statements and fully understanding my financial responsibility for all care rendered to me so long as I am a patient of this practice regardless of any changes in my insurance coverage.

Patient Signature (or responsible party if minor)

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Witness

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