Please Read Before Today's Appointment

As your partner in healthcare, it is important that we provide the following information to avoid any misunderstanding or disagreement concerning payment for professional services.

1) Insurance Validation: Please verify with your insurance that Dr. Lata Shridharan is IN-Network and recorded as your PCP. If not, many insurance plans would pay lower and hold you responsible for the rest. Also note that we are obligated to only go by what Insurance companies provide as confirmation of your insurance coverage. So please double check with your Insurance company that that your plan is active, current and paid.

2) Insurance/Agreement to Pay – I hereby assign the authorized benefits & direct that payment under any insurance policy plan to be made directly to Natural Pediatrics (NP) for any services rendered to me or to the Patient on behalf of NP. I agree to pay NP for all charges not covered by any Insurance or third party payer.

3) Separate Charge – If a procedure is performed at your office visit, there will be a separate charge for that procedure. This charge may be applied to a deductible. (Examples: ear wax removal, wart removal, nebulizer treatments, foreign body (object) removal, antibiotic injections, splinting/casting, some x-ray interpretations, lab tests performed, etc.)

4) Well / Sick Exam: Some insurance restrict what procedures (e.g. shots) or topics are covered during a well or sick visit. If, restricted by insurance, we may ask you to schedule a separate well or sick visit to cover your needs/concerns.

5) Hearing & Vision exams – These screenings are recommended at all annual well visits. Please check with the benefit department at your insurance company to make sure these screenings are covered. Some insurance companies put an age cap on well child visits, hearing screenings, and/or vision screenings.

6) Parents of Newborns – The hospital follow-up visit at 3-5 days of age is not a well child exam. The newborn visit is recommended to monitor weight loss, feeding & potential jaundice. Please check with the benefit department of your insurance company to understand your coverage.

7) Cancellation Fees - Please call us, at least 24 hours in advance, if you need to cancel an appointment. For appointments cancelled with less than a 24 hour notice, or for not showing up for an appointment, a $25 fee will be charged. (This applies to all types of insurance). Failing to keep scheduled appointments may deter you from receiving future services.

8) Co-pays, Coinsurance and deductibles: Copays are due at the time of service. If you have a high deductable plan, we collect a deposit upfront. Contact your insurance company to understand your coinsurance and deductible responsibilities. Please pay these promptly upon receipt of a statement from our billing dept. We need your support to pay our bills on time. Call our billing dept 972-618-3547 on any questions.

9) Telephone charges – Some telephone calls with your Provider are billed a small charge, as per insurance.

10) Medical Record Release: Depending on the complexity and time it takes, we may charge for release of Medical Records.

11) Arriving on time - We ask that you arrive 10-15 min before your scheduled time so that thorough check-in, updates, and measurements can be done before your scheduled time with your Provider. Events may cause you to be late, but late patients may be asked to reschedule.

12) Follow-up appointments: Our clinic follows national guidelines for recommended follow-up intervals for certain conditions or medications such as ADHD & asthma. The follow up visits are recommended so we can ensure the safety & health of your child. Even if your child is doing well and/or is stable on the medication, we are responsible for regularly assessing improvement, status, and risks.

13) Consent for Treatment – I hereby authorize Natural Pediatrics, or their designee(s), to treat my or the patient's condition as they deem appropriate.

14) Consent for Release of Medical Information – I consent to & authorize the use & disclosure of my child's protected health information for the purposes of treatment, payment, health care operations, school, daycare, sports & camp health forms, & quality assessment & improvement activities. I have reviewed a copy of the Notice of Privacy Practices from NP.

If you have other adults that take part in the care of your child, please share this information with them.

Parent/Guardian Signature: _____Date:_____