San Fernando Pediatrics & Urgent Care

107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888) 799-8585

Financial Policy

San Fernando Pediatrics & Urgent Care participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what are your particular benefits may be. Therefore, it is important to contact your insurance company if you have any questions regarding your benefits so that you know what your payment obligations will be at the time of service.

Primary insurance information

Insurance name: _____ Subscriber ID: _____ Group: _____

Secondary insurance information (if applicable)

Insurance name: _____ Subscriber ID: _____ Group: _____

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, or by credit or debit card. We also accept Health Savings Account (HSA) cards for payment. Please note that your co-payment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid or met your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so. Please ensure that if you are unable to bring your child in by yourself, whomever brings the child, is prepared to make all payments.

Credit Card on File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, it is our policy to have a valid credit card secured on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt may be sent to you by email or text to your mobile phone.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

Initials _____

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No-Show & Same-Day Cancelation Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of at least 1 business day for all cancellations. Failure to notify the clinic in a timely manner will result in a no show fee of $50 per individual patient appointment. Repeated no-shows will result in the family being advised to transfer care out of the practice.

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Authorization to Treat and Bill

I have read, understood and agree with the above financial policies. I consent to be treat by San Fernando Pediatrics & Urgent Care and any provider at this clinic. If I am not the patient, I am authorized to consent to treatment and billing for the patient identified below. I authorize Ali Anari MD, inc DBA: San Fernando Pediatrics & Urgent Care, to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill.

I authorize payment of medical benefits to San Fernando Pediatrics & Urgent Care. I understand that I am responsible for all charges for the treatment I receive. I understand that if I do not provide accurate and complete insurance information, San Fernando Pediatrics and Urgent Care may not receive payment from my carrier and I will be entirely responsible for my bill. Even after my medical insurance pays San Fernando Pediatrics & Urgent Care, I may owe payment for services not covered by my insurance and I agree to pay these promptly. I understand that San Fernando Pediatrics & Urgent Care may send lab specimens to an outside laboratory (QuestDiagnostics or LabCorp). I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that San Fernando Pediatrics & Urgent Care is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, San Fernando Pediatrics & Urgent Care may choose not to bill insurance and may decline to accept credit/debit cards or checks as a form of payment. I understand that if I fail to pay San Fernando Pediatrics & Urgent Care for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 35% in addition to the amount owed for services/treatment rendered. I understand that I may contact San Fernando Pediatrics & Urgent Care to work out payment arrangements that may prevent this additional cost.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

Initials _____