



# Meridian Pediatrics

Allyson Van Steenberg M.D.  
Angel Zieba M.D.  
Barbara Kissam M.D.

## PAYMENT, INSURANCE AND CLINIC POLICY

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU  
&  
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE**

**PAYMENT POLICY:** \_\_\_\_\_ Initials

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 30 days will be charged 1.5% per month or 18% per annum. In the event that any balance due is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs exceed 20% of said unpaid balance, including a reasonable attorney's fee.

**INSURANCE POLICY:** \_\_\_\_\_ Initials

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will be happy to submit to most carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. You are responsible for all deductibles and charges not covered by your insurance carrier. Please understand that as a third party, we cannot be involved in prolonged insurance negotiations; this is your responsibility.

**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS:** \_\_\_\_\_ Initials

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 the following purposes: diagnostic, insurance, & legal purpose. I further understand that any persons receiving these medical records will not release any of the medical information obtained by this authorization to another person or organization without a further authorization signed by me for release of information.

**LATE POLICY:** \_\_\_\_\_ Initials

In order for your physician to be able to provide the best care possible it is important to be on time for your appointment, therefore: **If you are more than 10 minutes late for your appointment, please be prepared to reschedule your appointment.**

**IMMUNIZATION RECORDS:** \_\_\_\_\_ Initials

Please bring your immunization card with you to every scheduled well child exam.

**PRESCRIPTION REFILLS:** \_\_\_\_\_ Initials

Please allow 48 hours for all prescription refills and utilize our prescription refill line.

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

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Printed name: \_\_\_\_\_