Desert Valley Pediatrics

☐ West Valley Office
4137 N. 108th Ave.
Phoenix, AZ 85037
P 623-877-7337
F 623-772-0686

☐ At The Ball Park
3802 N. 53rd Ave. Ste. 160
Phoenix, AZ 85031
P 623-877-7337
F 623-247-6537

☐ Surprise Office
15264 W. Brookside Ln. Ste. 155
Surprise, AZ 85374
P 623-877-7337
F 623-214-3219

Patient Office Policy Acknowledgment

Lab Work Policy

In the event that lab work is necessary, Desert Valley Pediatrics will do our best to send specimens to the correct laboratory contracted with your insurance company. If for any reason your insurance company denies a laboratory claim due to laboratory incorrect billing, services not covered under your plan, insurance change, or specimen being sent to the wrong laboratory, **Desert Valley Pediatrics will not be liable for your laboratory charges/fees.**

Financial Policy

The parent or legal guardian accompanying a minor to the office is responsible for full payment at the time of service. We cannot bill a third party (other than a contracted insurance company) or other parent if they are not present at the time of service.

For medical coverage with health plans we are contracted with, we will submit a claim for office visits, procedures, and hospital services provided by our physicians. You, the responsible party, will be required to make payment of your assigned co-payment or co-insurance at the time of service.

For medical coverage with health plans with which we are not contracted, please understand that we will collect for the visit in full at the time of service and then you may be reimbursed by your insurance company based on your policy benefits. As a courtesy, we will submit your claims to the insurance company unless you choose to do so yourself.

Desert Valley Pediatrics will not become involved in disputes between you and your insurance company, other than to supply factual information as necessary. You are responsible for any balance that your insurance company has not or will not pay. If your insurance company has not paid or denies benefits, please contact their claims department if there are any questions or complaints.

By signing this form, I acknowledge that I understand the Lab Work and Financial Policy.

Patient Name: _____ DOB: _____/_____/_____

Parent/Guardian's Signature: _____ Date: _____/_____/_____

Parent/Guardian's Printed Name: _____ Relationship to Patient: _____

(This form will expire 1 year from date of signature)

Witness (Practice Representative): _____