DVPeds
Desert Valley Pediatrics

No-Show Policy

A missed appointment leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a parent or legal guardian fails to give adequate notice that the appointment cannot be kept. The parent or legal guardian's failure to cancel or reschedule an appointment by 8:00 AM the day of the scheduled appointment will result in a no-show. If three (3) no-shows are accrued during a calendar year (Jan - Dec) the family will be dismissed from the practice and unable to receive future treatment at Desert Valley Pediatrics.

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. You are required to supply DVP with all medical insurance policy information that your child is covered by at the time of service.

As a courtesy, for medical coverage with health plans, 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 assigned co-payment, deposit towards deductible or deposit towards self-pay visit at time of service.

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.

Privacy Consent

We are concerned with protecting your privacy. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

By signing the form provided, you consent to our use and disclosure of protected health information about your child for treatment, payment, and healthcare operations as described in our Notice. **The Practice may condition receipt of treatment on this consent.**

You have the right to request, in writing, that we restrict the disclosure of health information about your child. We are not required to agree to this restriction but if we do, we will honor our agreement.

You understand that this consent will remain in force from this time forward and that it may be revoked by providing written notice.

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By signing this form, I acknowledge that I've read and understand the following policies:

No Show Policy

Financial Policy

Privacy Consent

Patient Name:_____ DOB: ____/____/____

Patient Name:_____ DOB: ____/____/____

Patient Name:_____ DOB: ____/____/____

Printed Name of guardian:_____ Date: ____/____/____

Signature of guardian:_____ Relation to Patient:_____

Because there may be times that you are not able to bring your child to an appointment you grant permission to the following person(s) to seek treatment on behalf of your child and allow DVP to disclose relevant healthcare information regarding that treatment. This authorization does not allow the person(s) listed below to obtain medical records regarding the patient(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Practice Witness: _____

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