Manhattan Valley Pediatrics Office Policies

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms by initialing each section.

TREATMENT FORMAT, FEES & PRACTICE POLICIES

☐ I understand that all outstanding payments are required at the time services are rendered. This includes applicable co-insurance, co-pays and deductibles as outlined by my insurance carrier.

☐ I understand that MVP may recommend certain visits such as the two week and three-month visits to assess growth and development which may **not** be considered well visits by my insurance carrier and as such may incur a co-payment, deductible or co-insurance for which I am responsible for.

☐ I understand that TeleHealth visits are subject to the same rules as all other visits including co-payments.

☐ I understand that my co-payment is expected at the time of my visit before my appointment.

☐ I understand that I will be charged a $50 fee if I fail to show for my well-visit.

☐ I understand that MVP reserves the right to cancel a well visit for which I am more than 10 minutes late.

☐ I understand there is a charge of $10 dollars for all school, camp and sports forms to be completed within 7 days forms that are not requested at the time of my child's well visit.

☐ I understand there is a charge $25 for expedited forms to be completed within 48 hrs.

☐ I understand that I need to sign up for the patient portal as a way to communicate non-urgent needs, access forms, and view lab work.

☐ I have read and agree to MVP's vaccine policy as outlined on our website www.manhattanvalleypediatrics.com

I understand and authorize MVP to release any information necessary to my insurance carrier regarding my child's condition or reason for visit to process insurance claims.

[redacted] _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date