Brian Despinasse II, M.D.
AND ASSOCIATES

FERTILE CRESCENT®
PEDIATRICS

730 Colonial Drive, Suite B • Baton Rouge, La 70806 • Phone: 225.924.7343 • Fax: 225.924.7347 • www.FertileCrescentPediatrics.com

Financial Responsibility

This form, when signed by me, confirms my understanding that all charges incurred by reasons of the treatment provided by Fertile Crescent Pediatrics, are my responsibility and shall be paid at the time the service is rendered. The only exception is if the doctor is a participating provider in your HMO/PPO. In this case, we will accept the insurance payment in full ONLY after all deductibles have been met and all co-pays have been paid. I further understand that if my insurance carrier requires a referral from my primary care physician, it must be presented prior to being seen by the doctor. Failure to provide all the necessary information, including a copy of my insurance card, may require me to reschedule my appointment.

Signature: ______________________________ Date: ______

NSF/Insufficient Funds/Returned Checks Policy

I acknowledge and understand that I will be responsible for any items returned as "Non-Sufficient Funds" as well as for an additional charge of $25.00 for each item returned. This is an administrative fee, not a charge that will be billed or paid by your insurance carrier. Once we accept a check and it is returned as "Non-Sufficient Funds", we will no longer be able to accept checks as a form of payment. All future payments must be made by cash or credit card. We accept VISA/Mastercard, American Express and Discover.

Signature: ______________________________ Date: ______

Missed Appointments

A scheduled appointment means that this time is reserved only for you. We request that if you cannot make you appointment that you give us 24 hours advanced notice. As a courtesy, we will remind you of your appointment the day before it is scheduled. If an appointment is missed without giving the office notice, a **$25.00** charge will be billed to your account. This is an administration fee, not a charge that will be billed or paid by your insurance carrier. Future appointments will not be made until this balance is settled.

I have read and understand Fertile Crescent Pediatrics Missed Appointment Policy.

Signature: ______________________________ Date: ______

Privacy Practices Acknowledgement

My signature confirms the fact that I have been provided an opportunity to review the enclosed Notice of Privacy Practices.

Signature: ______________________________ Date: ________

Witness: ______________________________ Date: ________