Reut Ron Pagi, MD
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Financial Policy and Payment Authorization
(Effective January 1, 2026)

Thank you for choosing My 1st Clinic as your child's health care provider. The following is a copy of our financial policy. Patient care is not permitted without the written consent of receipt and acknowledgement of the understanding of this policy.

1. Insurance & Billing

- **Verification:** It is the account holder's responsibility to verify with your insurance carrier that our clinic is in network with your insurance plan. Please provide a current insurance card and driver's license at every visit.
- **Account Changes:** Please notify us immediately of any changes to your insurance, copay amounts, or mailing address.
- **HMO Requirements:** If you have an HMO, Dr. Reut Pagi must be assigned as the Primary Care Physician (PCP) *prior* to your visit, or the appointment will be rescheduled
- **Well-Visit Billing:** While routine checkups are typically considered well-child visits, they often include assessments beyond the scope of insurance coverage for preventive care . While we generally do not collect copays for well-child visits, it's important to note that depending on how your insurance company processes the claim, you may be responsible for copays, deductibles, or other out-of-pocket costs after your visit. In addition, if a non-preventive issue is addressed during a well visit, it will be billed accordingly and your insurer may apply a copay, deductible, or other out-of-pocket cost for which you will be responsible.
- **Medi-Cal as Secondary Insurance:** We do not participate with Medi-Cal. Any patient responsibility determined by the primary insurance will be the responsibility of the account holder.

2. Payment Terms & Fees

- **Standard Payments:** Copays are due on the date of service. Balances are due upon receipt of the first billing statement. If an account has an open balance at the time of visit, the balance must be paid prior to the visit. We accept cash, check, debit, and all major credit cards. A $30 fee will be charged for any checks returned for insufficient funds. Accounts unpaid after 120 days will be sent to collections, and care for all family members will be discontinued.
- **Self-Pay:** If you do not have insurance and/or choose to proceed with self-pay, payment is expected at the time of service. A Good Faith Estimate will be provided upon request. We offer a 20% discount for all self-pay services paid in full on the day of the visit.
- **Missed Appointments:** We require 24-hour notice for cancellations. Missed appointments or late arrivals (10+ minutes) result in a **$75 charge** . Accumulating 3 missed appointments may result in dismissal from the clinic.
- **After-Hours/Holidays:** For urgent medical concerns outside of regular office hours, you may contact our after-hours service. A **$45 charge** applies for medical recommendations provided after hours.
- **Form Fees:** If parents request forms (e.g., school, camp, or sports physical forms) to be completed outside of a scheduled appointment, there will be a **$35 fee per form**. Please allow **3-5 business days** for completion.

3. Credit Card on File (CCOF) & Auto-Pay

- **Requirement:** A valid Credit Card on File (CCOF) is required to receive care at My 1st Clinic.
- **Billing & Auto-Charge:** Your total account balance—which may include "patient responsibility" amounts determined by your insurance (EOB), urgent after-hours call fees, missed visit fees, and form fees—will be automatically charged to the credit card on file at the **end of each month**.
- **Notifications:** The account holder will receive a text in the middle of the month stating that there is an outstanding balance. Balance may be checked on the patient portal or through your insurance portal (EOB). If you have any questions regarding the balance, you must contact our billing department at **(866) 371-6118** or your insurance carrier **before the end of the month** to resolve the inquiry prior to the auto-charge.
- **Dispute/Privacy Waiver:** In the event of a credit card chargeback or billing dispute, you provide consent for My 1st Clinic to release necessary protected health information (including, but not limited to, your Explanation of Benefits) to the merchant bank or credit card company to contest the dispute.
- **Installments:** Please notify the office in advance if you wish to arrange an installment plan.

4. **Domestic & Custodial Arrangements:** We do not mediate financial disputes between divorced/separated parents. The parent signing below is responsible for all payments regardless of custody agreements.

Authorization: I have read and understand this policy. I authorize My 1st Clinic to keep my credit card on file and charge unpaid balances according to these terms.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to Child/ren: _____