

The Pediatric Center
Financial Policy

We are committed to providing you with the best care, and we are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

ALL PATIENTS MUST HAVE A COMPLETE "PATIENT REGISTRATION FORM"

Full payment for services is DUE AT THE TIME THE SERVICE IS RENDERED unless other arrangements have been made with this office. We accept cash, personal checks, VISA and Mastercard. Please take your receipt after each visit, as it will show your current charges and any outstanding balance that you may have with the doctor you have just seen.

You will receive a separate billing statement for each doctor that your child sees. These separate bills should be paid with separate checks. After 60 days any account with an outstanding balance will accrue a \$3.00 rebilling charge each month until the account is paid in full. Delinquent accounts may be referred to a collection agency. If your account is sent to collections, your child will no longer be seen by any doctor in this office.

You agree that if it becomes necessary to forward your account to our collection agency, in addition to the amount owed, you will also be responsible for the fee charged to us by the collection agency for costs of collections, and reasonable attorney fees, along with any additional court costs awarded by the court.

We are not party to any legal agreement between divorced or separated parents.

APPOINTMENT CANCELLATION POLICY – We require a 24 hour notice of cancellation for all scheduled appointments, or you may be billed for that appointment. Insurance often will not cover this charge.

If you have health insurance it should be understood that this is a contract between you and your insurance company. Your doctor's bill is an agreement between you and your doctor.

INSURANCE PROGRAMS THAT CONTRACT DIRECTLY WITH US – YOU ARE RESPONSIBLE FOR UNDERSTANDING THE POLICY YOU HAVE CHOSEN, and for providing our office with all necessary billing information. Please read the benefits of you individual policy. There are some services that may not be covered by your insurance. Payment is expected at the time of service for non-covered charges. COPAYMENTS ARE REQUIRED AT THE TIME OF SERVICE. There will be a \$5.00 billing fee for all co-payments not paid at time of service.

REFERRALS – If your insurance plan requires a referral PLEASE CONTACT THE BUSINESS OFFICE BEFORE SEEING ANY PHYSICIAN OUTSIDE THIS OFFICE. Referrals must first be authorized by your physician and then called in to your insurance company by the business office. IT IS YOUR RESPONSIBILITY TO KNOW WHICH HOSPITAL AND LABORATORY YOU ARE REQUIRED TO USE.

INSURANCE PROGRAMS THAT DO NOT CONTRACT DIRECTLY WITH US – YOU ARE EXPECTED TO PAY IN FULL FOR YOUR OFFICE VISIT. We will give you a receipt to submit to your insurance company for reimbursement. You are responsible for your bill regardless of the status of an insurance claim.

MEDICAID – Every Medicaid patient must show a current Medicaid card at the time of service.

If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our business office. This will avoid misunderstandings and enable you to keep your account in good standing.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES, AND I AGREE TO ACCEPT RESPONSIBILITY FOR ANY FINANCIAL OBLIGATIONS INCURRED.

Signature

Date