



Thank you for choosing us as your child's pediatrician. We are committed to providing the highest quality comprehensive care for your child and we want you to completely understand our financial policies.

1. **Payment is due at the time of service** unless arrangements have been made in advance by your insurance company. We accept Visa, MasterCard, checks and cash.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, **we will file your insurance claim** if you assign the benefits to the doctor - in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurance, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an **assignment of benefits**. We will bill them and you are required to pay a **co-payment at the time of service**.
4. If your insurance plan has a **deductible**, you will be asked to pay at the time of service until the deductible amount, set by your insurance carrier, has been met.
5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an **unassigned basis**. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be **"not covered,"** you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
7. We will bill your insurance company for all services provided in the **hospital**. You are responsible for any balance due.
8. We follow a standard 30, 60, 90 day billing cycle. For bills not paid within 90 days, we reserve the right to discontinue care. Bills not paid within 120 days will be turned over to **collections**.
9. A \$25.00 fee will be charged for any **returned check**. Checks will be submitted twice to our bank. If your check does not clear the second time, then a cashier's check or money order will be required to pay for services.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

\_\_\_\_\_  
Signature of patient (or responsible party, if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print the name of the patient

\_\_\_\_\_  
SSN of Responsible party