

FINANCIAL POLICY

Thank you for choosing us as your health care provider for your child. Our main concern is that your child receives the proper medical care needed to maintain his or her health. If you have any Questions, please do not hesitate to ask our staff and/or doctors.

All co-pays and deductibles are due at the time of your visit. Payment for services for cash visits is due IN FULL at the time of visit. We accept cash, checks, Visa and MasterCard. For those with temporary hardships we have payment options we can offer.

We will submit insurance claim on your behalf if we have a provider contract with your insurance company. However, it is your responsibility to follow-up with your insurance company in the event that your claim is unpaid. If your insurance company changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately.

PLEASE READ THE FOLLOWING CAREFULLY:

- 1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.**
 - 2. Not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.**
 - 3. If you have Managed Care insurance, please make sure you have contacted them and named us as your primary care physicians or you will be responsible for payment of services.**
 - 4. Our office bills are for doctor services only. Fees for lab work or cultures are billed separately by the appropriate lab.**
 - 5. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collections and court costs.**
 - 6. Returned checks will be subject to a \$35 fee.**
 - 7. There will be a \$35.00 No Show fee for any appointment that is not cancelled or rescheduled.**
- We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate any problems so that we can assist you in the management of your account.**

Parent/Guardian Signature

Date

COLLECTION POLICY

Patient Name: _____

I, _____ hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

Returned checks: A \$30.00 Non-Sufficient Fund fee will be charged for checks initially returned unpaid by your bank. If the same check returned unpaid a second time, it may be referred to collection service for recovery.

Parent Signature or Responsible Party

Date

Witness Signature

Date