FINANCIAL AGREEMENT

I agree to pay the co- payment at the time of treatment. If co-payment is not received at time of service, I understand that my account will be charged an additional $15 out of pocket service fee. I further agree that I (parent/guardian/self) am responsible for all fees and services rendered for treatment of my child/children/self. As a courtesy, Town Pediatrics, PC will file claims for most major insurance carriers. I (parent/guardian/self) agree to verify with the insurance company that Town Pediatrics, PC, is a participating provider. I agree to adhere to the 30-day insurance policy of Town Pediatrics, PC. I understand that it is my responsibility to provide current insurance information within 30 days of the date of service. If I fail to do so, I will be responsible for the charges in full and Town Pediatrics, PC will not file the claim with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and your insurance carrier. Should any balances arise due to insurance copayments, co-insurance, deductibles, termination of coverage, non-selection of a primary care physician or not adding a dependent to insurance plan, non-payment at the time of service and / or any other reason I agree to promptly pay all charges. I agree that if for any reason my check is returned that I will be responsible for a $50.00 fee in addition to the amount of the claim. If the balance is not paid and/ or timely payments of this account are not made, I authorize Town Pediatrics, PC to retain the services of an attorney and/ or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility. This agreement is made on this day in the County of Loudoun and shall be governed by the laws of the Commonwealth of Virginia.

Patient Name: _____
Date of Birth: _____

Person with Patient: _____
Relationship to Patient: _____

I accept -
I decline-

5/2026