



Patient Account Number: _____

PAMPA PEDIATRICS FINANCIAL, BILLING, AND PRIVACY POLICIES

Thank you for choosing PAMPA for your child's healthcare needs. The information listed below is provided to avoid any misunderstanding and provide you with an understanding of our expectations.

Please note that the party that brings the child to the office will be responsible for the visit's copay or deductible plans deposit on service of \$50.00. We will NOT be involved in parental disputes.

- I authorize PAMPA to treat my child (children) and to release medical and billing information to the insurance company so that payment for charges can be processed.
- I understand that for PAMPA to file my insurance, I **MUST** present a valid insurance card at the time of each visit. I understand that my insurance is a contract between myself and the insurance company, not the provider, or this office, and my insurance company. I am responsible for balances after the primary insurance has paid and payment in full is due with the receipt of the statement.
- All unpaid claims after 60 days will be turned over to the patient so that you can follow up with the insurance company for payment. After 90 days, any unpaid balances will be prepared to be sent to the collection agency, unless financial arrangements have been made with the office.

*****We do not file Automobile, General Liability or Homeowner's insurance*****

- We accept cash, check, MasterCard, Visa, Discover or American Express. There will be a \$25 fee for all returned checks.
- **We offer office visits to our patients on Saturdays and Federal Holidays. Please note an additional charge will be applied to the visit on these dates.**
- I understand that PAMPA has an annual Administrative Service Fee of \$25 per child. This yearly fee is intended to cover the cost of certain administrative services which are not covered by my insurance. This fee does not cover the cost of copying medical records.
- If you find it necessary to cancel your appointment, we require AT LEAST 24 hours' notice prior to the appointment. Failure to cancel the appointment will result in a \$50 cancellation fee for Well and Med checks. This fee will double during Thanksgiving, Christmas, and all school break weeks. As always, emergencies and unforeseen circumstances are taken into consideration.

Signature of Parent or Responsible Party

Date

Address of Parent or Responsible Party

Primary Phone Number

Patient Name

Date of Birth

Patient Name

Date of Birth

Patient Name

Date of Birth