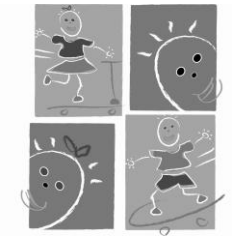

Avalon Park Pediatrics
Billing Agreement

Below are our billing practices for Avalon Park Pediatrics effective October 20, 2008 and forward, **PLEASE READ THE FOLLOWING DOCUMENT CAREFULLY AND SIGN ON BACK:**

I, _____, authorize Avalon Park Pediatrics to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to this facility. I authorize Avalon Park Pediatrics to release any medical or incidental information that may be necessary for either medical care or in the processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions for my insurance policy, to know which hospital, emergency rooms, laboratories, X-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule.

Credit Cards On File
All new patients must place a credit card on file. This credit card will be used for any services not covered by your insurance or any co pay or deductible amounts that were not collected at the time of service. Please see Credit Card on File Authorization information.

CO PAYS
All patients with a co pay are required to pay their co pay at the time of visit, prior to services rendered.

BALANCES
All patients with a balance are required to pay the balance plus their co pay or percentage if necessary, prior to services rendered. I understand that Avalon Park Pediatrics may dismiss my child from the practice for non payment of services.

DEDUCTIBLE PLANS
All patients on an insurance plan with a deductible are required to pay 90% of their visit at the time of service until the deductible has been met. Any adjustment received from your insurance company will be reflected in the additional 10% that will be owed after receiving the Explanation of Benefits from your insurance company.

***Copays, Deductibles, and Balances are due at time of visit, regardless of who brings the child to the appointment. Please make the appropriate arrangements for payment prior to your child's appointment. We accept Visa, Mastercard and Discover if you would like to call ahead and pay the copay, or you can send a check or cash with the person bringing your child to the appointment. Also, we will not post date checks, please make the appropriate arrangements for payment prior to your child's appointment.**

80/20 Plans
All patients on an insurance plan that requires a 20% payment at the time of visit will be required to pay 20% of the visit at the time of service. Any adjustment received from your insurance company will be reflected in the additional amount that will be owed after receiving the Explanation of Benefits from your insurance company.

90/10 Plans
All patients on an insurance plan that requires a 10% payment at the time of visit will be required to pay 10% of the visit at the time of service. Any adjustment received from your insurance company will be reflected in the additional amount that will be owed after receiving the Explanation of Benefits from your insurance company.

SELF PAY PATIENTS
All patients that are self pay are required to pay the full amount of the visit at the time of service.

SEPARATED/DIVORCED FAMILIES
For any family where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible to us for payment and is due when services are rendered. In the case that only a copay is due at the time of service, any charges deemed by insurance as patient responsibility are due to Avalon Park Pediatrics by the parent who authorized treatment.

If the divorce decree requires both parents to split the charges incurred, it is the authorizing parent's responsibility to collect from the other parent. Avalon Park Pediatrics will not act as a mediator in collecting our payments. If the account balance is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.

NO INSURANCE CARD AT THE TIME OF VISIT
Any patient that does not have their new insurance card at the time of service will be required to pay 50% of the visit at the time of service and provide insurance information within 2 weeks of the visit or the charges will become personal responsibility. Once insurance information is received and benefits are verified any credit amount can be refunded upon request or kept on the account for future co pays.

VACCINES
Additional paperwork and agreements may be required for certain vaccines as deemed necessary by the practice.

NO SHOWING OF APPOINTMENTS
A $50.00 No Show fee will be added to your account for any appointment that is not canceled 48 hours in advance.

RETURNED CHECK CHARGE
A $25.00 fee will be added to your account for all returned checks in additional to the amount of the check. After receiving one check for insufficient funds, your account will be placed on a cash or credit card only basis. Debit cards will not be accepted. Any balances due including mailed statements will need to be settled via cash, credit card or money order.

AFTER HOUR NURSE TRIAGE CHARGE
A $15.00 Triage Charge will be added to all accounts for patient calls that go to the Nurse Triage after 10:00pm.

AFTER HOUR REFILL CHARGE
A $25.00 After Hours Prescription Refill Request charge will be added to all accounts for any prescriptions approved and called in by Dr. Raley during non-operating hours.

TELEDOC CHARGES
Depending on the service provided a $50.00 Teledoc charge will be added to all accounts, when Teledoc is utilized either during or after office hours.

***We accept Visa, Mastercard and Discover. You can at any time make a payment over the phone.**
***We do not accept post dated or temporary checks.**

Any questions related to our billing practice can be addressed to the Office Manager Victoria Raley or Dr. Raley directly. A signed agreement of our billing policy will be kept on file for all patients.

I understand and agree to the above billing practices as set forth by Avalon Park Pediatrics. I understand that if I do not follow the practices I can be dismissed from the practice. I also understand that I will be notified as the billing policies are amended.

_____
Patient Name(s)

_____ _____
Signature of Parent/Guardian Date