PEDIATRIC PARTNERS, LLC
FINANCIAL POLICY

We would like to thank you for choosing Pediatric Partners for your child's medical care. Pediatric Partners believes providing and maintaining a positive and communicative physician-patient relationship with our families is essential. We want to make sure that you understand our financial policies relating to your responsibility and the responsibility of your insurance company. Please read this carefully. We will be happy to provide further clarification if needed.

Please sign the Signature page to document that you have read and understood these policies.

BILLING / PAYMENT POLICY:

Payment is required at the time of service for all co-payments, deductibles and coinsurance, as dictated by your insurance company. If you send your child to the office with another care giver (Grandparent, Nanny, etc.), please provide the caregiver with your insurance card and co-pay so your child can get seen. Pediatric Partners accepts cash, personal checks, VISA, MasterCard and Discover. There is a service charge of $36.00 for returned checks.

Co-Payments. Insurance carriers require that we collect your co-payment at the time of your visit. Your co-pay will be collected up front from the person bringing the patient for the visit. **PLEASE NOTE:** If your co-pay is not paid at the time of the service, there will be an additional $10.00 charge attached to your co-pay.

Uninsured patients / Self-Pay. If you do not have proof of insurance, payment is due at the time of your visit. A prompt pay discount is available if you pay in full at the time of the service. If the total charge amount is not available at the time of checkout, you will be required to pay a deposit to be applied to your charges. A refund will be issued if needed.

NOTE: If you have a Credit-Card-on-File (CCOF), you will not be required to pay a deposit at the time of the visit.

Credit Card on File (CCOF). This convenient payment method saves you from having to write checks, eliminates late fees, and saves paper. The account number is stored securely by our credit care processor. Pediatric Partners only has access to the last 4 digits of your account. After a transaction is completed, you will receive a receipt of any charges that are made to your card. If we are not able to receive payment from your card (e.g. it has expired) we will bill you immediately.

Telemedicine Visits. Telemedicine visits are treated like in-person visits. That is, all demographic information must be updated, the co-pay is due at the time of the visit, insurance coverage is your responsibility, and there will be a no-show fee as appropriate. This will not be charged if there were technical issues causing the cancellation.

After Hours Care:

This service is performed after 6 P.M., and on Saturdays and Sundays during regular business hours. This is considered a convenience service. Some of these services have additional charges associated with them. Most are recognized by insurance companies. Parents may be required to pay additional amounts for these services depending on the type of insurance plan you have and your coverage.

INSURANCE: It is your responsibility to update any information including your address, email, phone number, and current insurance information. You must present an active insurance card at every visit. Each insurance company may have several versions of coverage. It is your responsibility to fully understand your plan and any health savings accounts you may have. According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurance at the time of your visit. Pediatric Partners is not responsible if your insurance does not pay.

Occasionally, your child may have a significant illness or problem that needs to be addressed at the well visit. This may require an additional visit on another day or an added sick visit at the same time, either of which may require a co-pay as mandated by your insurance company.

If your Plan requires it, you must name Pediatric Partners as your Primary Care Doctor prior to your first appointment. If a Pediatric Partner's physician is not named on your insurance as your Primary Care Doctor, your appointment may need to be rescheduled. You do not need to be seen by that specific clinician; all the clinicians in the office will be covered.

If your insurance is not active at the time of the appointment, you will either be required to pay at the time of your visit or reschedule your appointment.

REFERRALS: You must receive a referral to specialists before the appointment. As per your insurance rules, no retroactive referrals will be given.

OUTSTANDING BALANCES: Outstanding balances are due upon receipt. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement. Payments from you are due within 30 days after denial by your insurance. Balances can be paid via our patient portal. Patients with an outstanding balance over 90 days overdue must make arrangements for payment prior to scheduling routine appointments, including Well Visits. Please call the billing office (410-876-5660) to pay your balance or set up a payment plan. You will be required to give a credit card to save on file.

PAST DUE ACCOUNTS: We will not see patients for routine exams / well visits / evaluations or follow up appointments if a patient's account is in collections.

NO SHOW / CANCELED APPOINTMENTS: If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $35 for no shows and appointments that are not canceled at least 24 hours in advance. This fee is usually not paid by insurance. This fee does not apply to Medicaid patients. Repeatedly missing appointments without adequate notice may result in discharge from the practice.

QUESTIONS ABOUT YOUR BILL: Please call the billing office at 410-876-5660, Monday through Friday, 9 AM – 3 PM. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent a child from receiving the care they need at the time they need it. However, if you ignore or fail to respond to your financial obligation, we reserve the right to discharge you from our practice. If your credit card is not valid, we will notify you; payment will be expected in 10 days from receipt.

FORMS: There is a $15 fee for the completion of forms. Payment is due at the time a form is dropped off or picked up. Forms will be complete in 5-7 business days.

MEDICAL RECORDS COPYING FEES: All record requests must be in writing on a record request form. We require 14 business days for completion of these requests. The fees are determined by state law and are available on the MedChi website. Any patient over 18 years of age must sign their own release form. A copy of the patient chart is $20.00 + cost of postage. Payment for this service is required at the time of the request or when the records are picked up. You have the option to pay for this on the portal.

SIGNATURE SHEET

Patient's Name	Date of Birth	Patient's Name	Date of Birth
Patient's Name	Date of Birth	Patient's Name	Date of Birth

ASSIGNMENT OF BENEFITS

I hereby authorize any provider of Pediatric Partners, LLC to apply for benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to such providers. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. A copy of this authorization may be used in place of the original. _____(INITIAL)

CONSENT TO TREAT

I (or my legal guardian or parent) authorize Pediatric Partners, LLC to provide medical care reasonable by today's standards, including sharing of necessary information with insurance companies and pharmacies to allow e-prescribing. _____(INITIAL)

HIPPA / RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Pediatric Partners, LLC, Notice of Privacy Practices, which provides information about how we may use and disclose your protected health information. _____(INITIAL)

FINANCIAL POLICY

I have carefully read, understand, and agree to Pediatric Partners' Financial Policy dated 2026.

X_____ _____

Parent / Guarantor Date

CARD ON FILE

I authorize Pediatric Partners, LLC, to charge my credit card on an ongoing basis for balances owed, per my insurance, as outlined in the Financial Policy. I understand my information will be saved on file for future transactions. I understand I must cancel this authorization through written notice. I agree to contact Pediatric Partners if there are any changes to my credit card account information. The signature below will serve as the credit card authorization signature.

CREDIT CARD INFORMATION

_____MasterCard _____Visa _____Discover

Cardholder Name (as shown on card): _____

Card Number: (last 4 digits) _____ Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

_____ _____

Signature Date