Patient Payment Policies

Patient Name: _____ Patient #: _____

Please initial and pay close attention to each of these statements. This information is important for you to know and understand.

1. _____Copayments are due at the time of the visit. If the copayment is not paid in full on the day of the visit, or a copay agreement is not signed, an additional $10.00 service charge will be added to the patient balance for the date of the visit.
2. _____If your commercial insurance does not have a set copayment amount, a payment of $20 will be collected towards the coinsurance or deductible amount prior to being seen.
3. _____If the bank returns a check for insufficient funds or if you give our office a credit card to charge as part of a payment plan agreement and it is declined, a $25.00 service charge will be added to the patient balance for the date of the visit.
4. _____If a patient does not have insurance, payment must be paid in full at the time of service.
5. _____If a patient has a balance due, payment will be required within 30 days of your first statement. If the balance cannot be paid in full within that time period, a signed payment agreement must be completed with a credit card kept on file, to be charged monthly. Balances that are not paid and/or a payment agreement is not made at 60 days from the statement date will be assessed a late fee.
6. _____ If a payment plan must be executed for an outstanding balance, all future appointments must be paid on the date of service, prior to being seen. The payment amount will be assessed according to your specific insurance plan's copayment, coinsurance and deductible amounts.
7. _____If Firefly Pediatrics finds it necessary to take steps to collect a past-due balance, the patient is responsible for all costs involved in collection, including court costs.
8. _____If a patient files bankruptcy, future appointments must be paid prior to being seen. The amount will be assessed according to your copayment, coinsurance and deductible amounts. Patients with current, active Medicaid (TennCare) are excluded from this policy.

By my signature, I acknowledge understanding of the policies stated above and agree to comply with these policies.

Responsible Party Signature _____ Date _____

Relationship to Patient _____