PRESTON HOLLOW
PEDIATRICS

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are eager to help you maximize the benefits of your medical insurance, if applicable. We will file insurance claims with companies with which we have a contracted agreement. The following is information we hope will help you understand our insurance and financial policies.

Please Initial Below

_____ **Copays & Collections:** Copays, coinsurances and deductibles are due at the time of service. Payment is required for any past-due balance before your next visit. You may be asked to reschedule your appointment if unable to make payment. We accept cash, checks, and debit/credit cards. There is a $50 fee for returned checks. Accounts unpaid after 90 days are turned over to a collection agency. An additional $50 fee is added to the patient's balance once the account is turned over to a collection agency.

_____ **Fee-for-Service:** We are a "fee for service" practice. This means that if you are a self-pay account (no insurance or insurance we don't file), payment is due in full at the time of service. A self-pay discount is included in the self-pay rates. If we accept assignment of benefit and file with your insurance, any deductible or copays are due at the time of service.

_____ **Covered Benefits:** The fee for any service, procedure and/or supply that is not considered a covered benefit under your insurance plan is due at the time of service (if known) or is billed to your patient account after insurance denies coverage. While we attempt to estimate which services, procedures and/or supplies will be covered, it is the patient's responsibility to understand their insurance plan, coverage, deductibles and co-pays.

_____ **Responsible Party:** The patient is responsible for payment of the account. If a party other than the patient (e.g., a spouse or family member) will be responsible for the account, that arrangement must be confirmed in writing with our billing office.

_____ **Forms Fee:** Any form requiring a provider's signature will be completed for a $10 fee. The fee is not applied if the form is to be completed during an annual wellness visit or a sports/employment physical.

**Practice Policies and Fees are subject to change at any time without notice.*

If you have any questions, we will be happy to assist you.

Patient Printed Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____

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