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. The adult accompanying the patient is responsible for any payment due. Payment is required for any past due balance prior to 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 balance once 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. There is a self-pay discount 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.

_____ **Account Guarantor:** In the case of divorce, without regard to the terms of a divorce decree or court order, the parent bringing the child in for a visit is financially responsible for payment of the account or the account guarantor. We are unable to negotiate settlement of medical bills between you and your ex-spouse.

_____ **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 a well child check or sports physical.

*F9jf*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: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Today's Date: _____

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