pediatric care corner

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Financial Agreement

Patient: _____ Date of Birth: ____ / ____ / _____

1. Payment is due at check in. We accept cash, checks, and credit (Visa, MasterCard, Discover, and American Express).
2. **All co-payments are due at time of service.** ***A $10 late fee applies to copays not paid at your visit. All other insurance balances must be paid in full within 30 days. Please note that overdue balances and returned checks may incur additional fees.*** **_____Parent/Guardian Initials**
3. Please discuss insurance problems and financial arrangements with the billing office staff.
4. **No Show Appointments: Cancellation of well or sick appointments with less than 24 hour notice will be charged a $50.00 fee. Three no shows within 12 months may result in patient dismissal. _____Parent/Guardian Initials**
5. Our office will submit claims to your insurance company. It is important that you know what services your insurance covers. Services that we render that are not covered by your insurance plan are your financial responsibility.
6. **In accordance with National Coding Guidelines, charges may be applied to services rendered during regularly scheduled evening (after 5:00p.m.), weekend, or holiday office hours in addition to basic services rendered.** ***These charges may be passed on to the patient if insurance coverage does not cover this service.*** **_____Parent/Guardian Initials**
7. If your insurance is an HMO (Health Maintenance Organization) that requires a designated PCP (Primary Care Physician) and we are not identified as your PCP prior to your visit, you will be financially responsible for any fees incurred. If your child needs services that require a referral, please contact our office as soon as possible to make that request. Referrals must be authorized by the doctor and may require an office visit. Authorization from your insurance plan for your referral may take one or more weeks. Subsequent visits, procedures, testing, surgeries, and hospitalizations typically require additional referrals.
8. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware.
9. If you are experiencing financial difficulties, please discuss this with the billing office staff. We will gladly work with you to make payment arrangements. Delinquent accounts may be referred to a collection agency, and such accounts may be reported to a national credit agency. You agree that we may charge you reasonable collection fees and attorney fees if we are forced to refer your past due account to a collection agency and / or attorney.
10. There will be a charge for the preparation and completion of the following: FMLA forms and medical record copies.
11. If you are bringing your child in for a preventative visit and you bring up an acute problem in the room with the physician and he/she addresses the acute problem, be advised this may be billed to your insurance as a separate encounter and you may incur additional charges that may be your responsibility. Preventative and sick visits should be scheduled separately.

***** We will be charging your insurance for doctor calls exceeding 5 minutes per day or nurse-only calls exceeding 15 minutes. Brief calls taking less than these thresholds will remain complimentary. Whether you have a cost share is determined by your insurance plan and policy. If you have questions about our policy, please contact our billing office.***
_____Parent/Guardian Initials

A current version of our financial agreement is posted on our website at **www.pedcarecorner.com**. Future revisions may require a new signed financial agreement from each patient. We sincerely appreciate your cooperation and are happy to assist you in any way we can.

I have read, understand, and accept the above statements.

Print Name of Parent /Guardian: _____

Parent / Patient / Guardian Signature _____ Date Signed: _____