

FINANCIAL POLICY FOR ALL ABOUT CHILDREN PEDIATRICS



Payment is due at the time of the office visit unless previous arrangements have been made with one of our billing staff. As the patient or the patient's guarantor you are responsible for finding out the status of any insurance claims our office may have filed for you. All charges associated with your office visit or any other procedure performed on your child is your responsibility. We will file your claim twice with the insurance you provide to us at the time of your visit. We will then look to you for payment on any unpaid claims. If you fail to make us aware of any changes to your insurance carrier at the time of your visit, the responsibility for payment for your office visit and subsequent reimbursement from your new insurance carrier will be yours. If there is more than one child in our practice and there is an insurance change, you are responsible for making us aware of the changes for each child specifically.

It is your responsibility to determine if our providers are on your specific HMO, PPO, EPO, or POS plan. If we are providers for your health insurance plan and have a copy of your insurance card, we will file your claim. If your insurance is an HMO, EPO, or POS plan and we are not the primary physician listed on your card, we might have to reschedule your appointment since benefits may not be paid, or you can pay for the office visit and seek reimbursement from your insurance plan.

If you have no insurance coverage you will be made aware of our policy regarding payment of services at the time your appointment is made.

If payment is not received in a timely manner, your account will be turned over to a collection agency and you will be responsible for a \$25 service fee. A returned service fee of \$25 will be charged for any checks that are returned NSF.

If the patient is a minor (anyone under the age of 18) a parent or legal guardian must be in attendance to give consent for treatment and be the responsible guarantor. In a divorce situation, the parent who brings the dependent child to our office is responsible for payment. Insurance may be filed, but the parent in attendance will be responsible for any copay or outstanding balances.

AUTHORIZATION FOR PAYMENT

I authorize payment of medical benefits to ALL ABOUT CHILDREN PEDIATRICS.

My signature below indicates that I have read, understand, and agree to the above terms. I hereby authorize ALL ABOUT CHILDREN PEDIATRICS to evaluate the person that I am legally responsible for or me (relationship listed below) for any illness or injury for which I seek medical care.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to ALL ABOUT CHILDREN PEDIATRICS. This assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Responsible Party: _____ Date: _____

Patient's Name: _____ Relationship: _____