

PRIMARY PEDIATRICS FINANCIAL POLICY

We are pleased to have you as a patient and we are committed to providing you with the best medical care possible. We ask that you read and sign this statement. We must emphasize that as medical care providers, our relationship is with you and *not* your insurance carrier. As a courtesy to you, we may file your claim however *you* are responsible for charges incurred from the date services are provided, unless our contractual agreement with your carrier states otherwise. Co-payments are due at the time of the each visit. We also request that you make payment for services rendered at the end of each visit. Full payment is expected for all miscellaneous charges not covered by any insurance carrier (e.g., medical forms and ear piercing). We accept cash, checks, money orders, and MasterCard or VISA. There will be a \$35 fee for all returned checks. In view of the ongoing growth and change in available health care plans, it is imperative that you understand your benefits and responsibilities *prior* to being seen at Primary Pediatrics.

ADDITIONAL INSURANCE POLICY INFORMATION

In order to assist you in receiving the maximum benefits allowable by your insurance company we ask that you provide us with the insurance card at each visit. You must keep us informed of all changes and updates with your contact and insurance information. Remember as a courtesy to you, Primary Pediatrics will file your *primary* insurance claim once, provided that we have complete insurance information at the time of service. We do not file third party or worker compensation insurance claims unless contractually obligated to do so. All deductibles and co-payments are due at the time of service. Any insurance balances not paid within 90 days will be changed to patient responsibility.

SELF-PAY

Patients without health insurance will be expected to pay in *full* for all services rendered at the time of service. Any special payment arrangements must be set up with the Billing Office prior to the visit. We accept cash, checks, money orders, and MasterCard or VISA.

CANCELLATION POLICY

We request that appointment cancellations or changes be made at least 24 hours in advance. We reserve an appointment time exclusively for you. Without proper notification we cannot utilize the time slot you vacate to care for someone else. A fee of \$15.00 will be added to your account for a missed appointment.

LAB/REFERRALS/MEDICAL EQUIPMENT

If a comprehensive evaluation from a specialist, lab work and/or radiography is requested by Primary Pediatrics to be performed following our examination, please remember that these are separate entities and will require your insurance and billing information.

RESPONSIBILITY

Our Billing Office is available to assist you with any insurance or accounting concerns. Please feel free to call (877) 589-7851 for assistance.

By my signature below I acknowledge to the following statement. "I understand that I am responsible for any outstanding balances. In the event my account is turned over to collections, I will be responsible for any and all collection costs, interest, Attorney's fees and Court costs. I have read, understand and agree to abide by the policies of Primary Pediatrics as stated in this document".

Print name: _____

Signature: _____

Date: ____/____/____

Thank you for choosing Primary Pediatrics, P.C.