ABC Pediatrics

Summary of Financial Policy and Authorization

Thank you for choosing ABC Pediatrics as the provider of your child(s) healthcare needs. Please read the following summary of our financial policy and sign where indicated. You may also ask for a copy of the ABC Pediatrics' detailed financial policy or review it on our website at www.myabcpediatrics.com

PAYMENT POLICY

Payment is expected at the time of service. We accept cash, check, and credit cards- American Express, MasterCard, Visa, and Discover.

INSURANCE

We agree to accept assignment for any insurance plan with which we are participating providers, and will file insurance claims on your behalf. CO-PAYMENTS, any ESTIMATED CO-INSURANCE and/or your DEDUCTIBLE are EXPECTED AND DUE AT THE TIME OF SERVICE. In the event you do not have insurance coverage, payment is expected in full at the time of service. We do offer a payment plan provided you have a positive credit history with ABC Pediatrics and have submitted your request in advance of treatment.

Charges are ultimately your responsibility. Your benefits coverage is based on your plan with your insurance carrier; therefore it is your responsibility to know your benefits. We ask that you contact to your insurance carrier prior to any visit and that you follow-up with your insurance company in the event of any dispute or issues with a claim.

DELINQUENT AND COLLECTION ACCOUNTS

You will receive up to three patient statements for any balances on your account after the insurance payments and adjustments have been applied. Any unpaid delinquent debt (no payment received after 90 days of services rendered), including no-show fees, owed to ABC Pediatrics will be referred to an outside collection service and will be reflected on your personal credit report.

You will be responsible for all additional collection agency expenses incurred by ABC Pediatrics in the course of obtaining payment, and the family on the account will be permanently dismissed from ABC Pediatrics. The collection agency expense is currently 30% of outstanding balance.

AUTHORIZATION

- I hereby certify that the information I have provided regarding my (child's) insurance, our address and phone numbers is correct.
- I understand that fees charged are due at the time of service and charges are ultimately my responsibility, regardless of my insurance.
- I hereby authorize ABC Pediatrics to apply for benefits on my (child's) behalf for covered services rendered. I request payment from my insurance carrier be made directly to ABC Pediatrics.
- I authorize the release of any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time by submitting a request to ABC Pediatrics in writing.
- I acknowledge by my signature that I have read and do understand this financial policy and authorization. I also acknowledge that I will be responsible for payment of services, co-pays, co-insurances, deductibles, or non-covered services by my insurance company.

Print Child's Name: _____Date of Birth _____

Parent/Guardian Signature:_____ Date_____

Revised Date: May 2014