THE PEDIATRIC CENTER P.A.
FINANCIAL POLICY

1. All patients parents or guardians are responsible for 100% of charges incurred for treatment by The Pediatric Center, P.A.
   a. The patient or guardian who signs the financial policy statement is the responsible party.
   b. New and/or uninsured patients are expected to pay their charges at the time they are seen.
   c. Whoever brings the child must pay same day expenses; copays, etc.
2. Established patients whose insurance has been verified and whose deductibles have been met will be expected to pay that portion of charges not covered under their policy and/or the policy's co-payment amount.
3. Insured patients who have not met their deductible will be responsible for paying all visits in full until their deductible has been met.
   a. Patients that are covered under well child care, in which the deductible is waived, are expected to pay that portion of charges not covered by their insurance on the date of service.
   b. Patients whose insurance does not have well child care are expected to pay 100% of all charges incurred that day of visit.
   c. Uninsured patients are expected to pay 100% of charges incurred the day of their visit.
4. Insurance in no way negates the patient's responsibility for the payment of their medical charges. With the exception of those HMO's and PPO's with which we participate, charges not paid for any reason by the insurance company are the patient's responsibility to pay.
   a. If you have new insurance - you must arrive 30 minutes before your scheduled appointment and present the card for verification. If insurance can not be verified, you must leave a check on hold or payment on your credit card - which will be refunded when insurance pays claim.
5. Patients may pay by local check, cash, Visa, Mastercard, and American Express.
   a. All checks over $100.00 will be verified with the bank.
   b. There will be a $40.00 service charge applied to your account for any checks that are returned, and payment will be expected in full that day by cash.
   c. There will be a charge for "No Show" appointments or cancellations made without 24 hours prior notice. For regular appointments the charge will be equal to $15.00 or your insurance co-payment, and for physicals the charge will be $30.00.
6. Patients who fail to pay their outstanding balances to us within ninety (90) days will be turned over to a collection agency. You still will be responsible for this bill, together with all collection costs, including a reasonable attorney fee in the event it becomes necessary to seek this method to collect payment.
7. Patients who have had an outstanding balance for ninety (90) days and have been turned over to a collection agent will be discharged from our practice and must find another pediatrician with whom to continue their care.
8. We have developed this Financial Policy because statements and billing have become so expensive, and in an effort to keep your medical costs down we ask that you comply with your financial responsibility. The staff is here to help you. If you have any questions regarding insurance filing, fees, or your statement, please speak with our office manager.

I _____, have read the above statement of FINANCIAL POLICY and understand its terms and agree to accept them.

_____ _____
SIGNATURE DATE

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