



Patient's Name _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our FINANCIAL POLICY which must be read and signed prior to your treatment.

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance you will be billed after we hear from them. As a courtesy we accept cash, checks, Visa, MasterCard, Discover and American Express.
2. If you have an HMO or PPO insurance plan with a designated primary care physician(PCP), please make sure you have selected a Physician in our office or you will be required to pay the entire fee at the time of service.
3. All CO-PAYS must be paid the day of your appointment.
4. Not all services are a covered benefit in all contracts. If you have a question regarding benefits you will need to call your insurance company and check benefits. This is not a responsibility of the physician's office.
5. Your insurance policy is a contract between you and your insurance company.
6. All services must be paid in full within 30 days after the insurance has paid.
7. If your visit is due to a Motor Vehicle Accident (MVA), those services are expected to be paid within 30 days. It is not the physicians' responsibility to get involved with MVA's. Our office cannot wait on MVA settlements.
8. Divorce decrees are NOT recognized by our office. The person who brings in the child is ultimately responsible for the bill. This office will NOT get involved in court decisions.
9. Accounts become past due after 60 days. We reserve the right to send an account to our collection agency if the balance is not paid in full in the 60 day time frame. An additional collection fee of \$36.00 may also be applied.
10. Please be aware that insurance is not a guarantee of payment and that some and perhaps all of the services may not be covered or not considered "reasonable and customary" by your policy and will be your responsibility to pay. We must have a current copy of your insurance card or enrollment form, in order to submit to your insurance company.

I hereby acknowledge that I have read, and understand and agree to the terms of this financial policy.

_____ Date _____

CONSENT OF TREATMENT

The physicians of Pediatric Care North, Inc. have my permission to provide my child with any necessary medical treatment.

The following persons have my permission to seek medical attention for my child _____ in my absence.

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

Parent's Signature _____ Date _____