The Pediatric Specialists Medical Group

Financial Policy

Patient Name:______________________________ **Date of Birth:**_______________

Basic Policy: Payment for services rendered is due at time of service.

For Patients with Insurance: We will bill most insurance carriers for you if **all** the necessary information is provided. **Co-payments and all outstanding account balances are due at time of service**. If your co-pay or balance is not paid at time of service **there will be a $5.00 charge to bill it**. As a courtesy, we research why an insurance company has not paid. If an insurance carrier held payment of a clean claim after 60 days of billing, fees are due and payable in full from you. All outstanding balances are due within 30 days of the statement. **Bills not paid within 30 days of the statement will be assessed a $25.00 per month re-billing charge** unless prior written arrangements have been made. All balances that reach 90 days past due will be sent to our lawyer for collections. You will be responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

Payment Method: We accept cash, Visa, MasterCard, debit cards, and local (non-starter) checks. Any account having a check returned for insufficient funds will be charged $30.00 and no future check payments will be accepted.

Minor Patients: The adult accompanying a minor will be responsible for full payment or insurance co-payments.

Divorce Decrees: This office is not party to your divorce decree. The adult accompanying a minor is responsible for any co-payments or balances on accounts.

Noncovered Services: Any care not paid for by your insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Wellcare and/or Preventative Care: Periodic preventative health services are recommended by the American Academy of Pediatrics may or may not be covered under your health insurance policy (It is your responsibility to check your coverage). For your child's well being, your physician will require them.

Insurance Patients: Signature on file & assignment of benefits.

I request and assign to **The Pediatric Specialists Medical Group** all insurance benefits otherwise payable to me for services rendered. I authorize the doctor to release all information necessary to secure the payment of benefits.

I understand my signature requests that payment be made to the provider of services, and authorize the release of medical information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

______________________________ ______________________________

Parent/Guardian Name (please print) Parent/Guardian Signature

I have read, understood, and agreed to the terms of the above financial policy for payment of professional fees. As the parent/legal guardian requesting medical services, I understand that I am accepting financial responsibility for any charges for visits that are not covered by insurance. I also understand and agree that the terms of this financial agreement may be amended by the practice at any time without prior notification to the responsible party.

______________________________ _______________

Signature Date

(727) 375-KIDS (5437) • Fax (727) 375-0502