Associates in Pediatrics

Guarantor: Please review our financial conditions. By signing below, you are agreeing to be bound by these terms.

Office Policy: Balances on all accounts are due at the time of service, unless other arrangements have been made. Account information such as mailing address, emergency contact phone number, must be kept up to date. Identification and Insurance card may be asked for at each visit, policy holder's or guarantor's date of birth and social security number are required for account verification.

Medical Services: In compliance with national guidelines, Well child checks do not include medical, diagnostic or prescription management. If your child receives services for a diagnosis that is symptomatic, another visit charge will be incurred. Your insurance may require patient copay in this situation. Medication refill request, referrals and form completion will take 72 business hours.

Self-Pay Services: Self-Pay patients are required to pay for the service in full at the time of visit. A self-pay, same-day payment in full discount will be applied to the visit if all balances on guarantors accounts are satisfied. A ten dollar Fee exist for each form that is not brought or requested during the yearly preventative check. Medical Record search and copy fee's for requested records are priced at state allowed rates.

Non-Covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial. You will be responsible for communicating with your carrier regarding denied services.

Returned Checks: Checks returned to us by your bank will be assessed a bank return check fee of $50.00.

Missed Appointments: Courtesy Appointment reminder calls are made to confirm you will be at your child's scheduled appointment. Failure to keep your child's appointment without providing a 24 hour notice will result in a $50.00 No Show fee, or if rescheduling a $25.00 rescheduling fee. Providing proper notice allows for that time slot to be given to another patient.

Unpaid Balances: Charges reflected on billing statements are agreed to be correct and reasonable unless disputed in writing within thirty (30) days of the billing date. All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum.

I have received a copy of the Notice of Privacy Practices. I understand that Pediatric Partners of Va. has the right to change its Notice of Privacy Practices from time to time and that I may contact at any time to obtain a current copy of the Notice of Privacy Practices. _____ Initials

Consent to treat and release medical information: I hereby authorize and assign all medical and/or surgical benefits, to include any medical benefits to which I am entitled, and private insurance, to the rendering physician. I authorize said assignee to release all information necessary to satisfy national healthcare and quality standards as well as secure payment for services rendered. I also understand that I am responsible for all charges (including non-covered charges) arising from the treatment of the above named patient. Should this account become delinquent, I agree to pay fees for any collection agency placement. These fee's may be based on a percentage of 30% of the debt and all cost, expenses and reasonable attorneys' fee's that are incurred for debt collection efforts. I certify that the demographic information provided on the registration form is true to the best of my knowledge. I understand that I may be contacted by e-mail, or any address/phone number on the account including cell phone lines. I have read, understood and agree to be bound by the terms of this financial policy. By signing this form, you are giving permission for your child or ward to receive recommended vaccinations and treatments as discussed by the physician. This signature is valid until notification in writing is received.

Printed Name: _____

Signature: _____

Witness Initials: _____