**First Choice Pediatrics**

**Financial Agreement 2020-2021**

**Financial Responsibility**: Payment is due in full at the time services are rendered, regardless of divorce decrees or if the party accompanying the patient is not the parent/guardian. Our practice accepts cash (no bills larger than $20), checks up to $30, and majority of credit cards. If a check is returned from the bank, a $25 returned check fee will be assessed.

**Insurance Plans:** We will submit claims to primary insurance companies with which we are participating providers. We cannot send claims to any insurance company we are not contracted with. Parents/guardians are ultimately responsible for all charges incurred if an insurance company does not pay within 60 days of the date of claim submission, or if the services are not covered on the patient’s insurance plan. Our office will attempt to verify the medical coverage as a courtesy; however, this is not a guarantee of coverage or payment by the insurance company.

**It is the sole responsibility of the parent/guardian to understand the patient’s coverage, including maximum benefits, copays, or deductibles, and PCP assignment, as well as provide our practice with current insurance information and identification numbers**.

**It is your responsibility to inform us immediately of a change in insurance or a mailing address.**

**Account Balances:** Our office sends statements once a month for any unpaid balances to the address that was provided by the party that brought the patient to the office. It is the parent/guarantor’s responsibility to update contact information, including addresses and/or phone numbers. Payment must be paid within 60 days from the date of the first mailed statement. Any balance that becomes past due will be considered for referral to a collection agency and our practice will no longer provide medical care to the patient and siblings.

**Appointments:** Any appointment not cancelled 24 hours prior to the appointment time will be considered a missed appointment and a $15 rescheduling fee may be assessed, $50 charge for a missed circumcision appointment. Three or more missed appointments on an account (which consists of all patients in the family), may result in dismissal from our practice. This fee is not covered by insurance plans.

**Continuity of Care:** All children should be evaluated by their primary care physician, as part of a routine physical, according to current AAP guidelines. We require all our patients to follow these guidelines so that we can monitor their development and growth. Failure to do so may result in dismissal from our practice.

**Consent: I hereby give consent to First Choice Pediatrics to provide the necessary treatments for my child(ren)’s medical care. I have received a copy of the Privacy Policy. I authorize First Choice Pediatrics to use or disclose pertinent information to coordinate my child(ren)’s medical care. I authorize payment for covered healthcare services performed to be paid to First Choice Pediatrics.**

**I give my permission for First Choice Pediatrics to leave phone messages regarding my child(ren)’s medical information, laboratory results, test results, or appointment information. If I choose to restrict First Choice Pediatrics from leaving messages at the phone number on file, I will notify the practice.**

PARENT/LEGAL GUARDIAN ACCEPTANCE OF THESE POLICIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Child(ren)

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_