Summary of Financial Policy and Authorization

Thank you for choosing Children's Care Pediatrics as the provider for your child (ren) healthcare needs. Please read the following summary of our financial policy and sign where indicated. You may also ask for a copy of the Children's Care Pediatrics financial policy or review it on our website at www.childrenscarepediatrics.com.

PAYMENT POLICY

Payment is expected at the time of service. We accept cash, check, and credit cards-American Express, MasterCard, Visa, and Discover. Under Georgia State Code #13-6-15, there will be a charge of $30 or 5% of face amount of the returned instrument (whichever is greater) plus the fee incurred by Children's Care Pediatrics from the processing bank.

INSURANCE

We agree to accept assignment for any insurance plan with which we are participating providers, and will file insurance claims on your behalf. CO-PAYMENT, any ESTIMATED CO-INSURANCE and/or DEDUCTIBLE are EXPECTED AND DUE AT THE TIME OF SERVICE. In the event you do not have insurance coverage, payment is expected in full at the time of service. We do offer a self pay plan that could be applied to the visit if needed.

Charges are ultimately your responsibility. Your benefits coverage is based on your plan with your insurance carrier; therefore it is your responsibility to know your benefits. We ask that you contact your insurance carrier prior to any visit and that you follow-up with your insurance company in the event of any dispute or issues with a claim.

DELINQUENT AND COLLECTION ACCOUNTS

You will receive up to two (2) statements for any balances on your account after the insurance payments and adjustments have been applied. Any unpaid delinquent debt (no payment received after 60 days of services rendered), including no-show fees, owed to Children's Care Pediatrics will be referred to an outside collection agency.

You are responsible for all additional collection agency expenses incurred by Children's Care Pediatrics in the course of obtaining payment, and the family on the account will be subject to permanent dismissal from the practice. The collection agency expense could be a much as 50% of any outstanding balance.

AUTHORIZATION

- I hereby certify that the information I have provided regarding my (child's) insurance, our address and phone numbers is correct.
- I understand that fees charged are due at the time of service and charges are ultimately my responsibility, regardless of insurance.
- I hereby authorize Children's Care Pediatrics to apply for benefits on my (child's) behalf for covered services rendered. I request payment from my insurance carrier be made directly to Children's Care Pediatrics.
- I authorize the release of any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time by submitting a request to Children's Care Pediatrics in writing.
- I acknowledge by my signature that I have read and do understand this financial policy and authorization. I also acknowledge that I will be responsible for payment of services, co-pays co-insurances, deductibles, or non covered services by my insurance company.

Print Child's name____ Date of Birth:__________________

Parent/Guardian Signature____ Date __________________________