Pediatric & Adolescent Associates, P.S.C.
FINANCIAL POLICY

Thank you for choosing Pediatric & Adolescent Associates, PSC as your pediatric primary care provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients/parents must complete this form prior to seeing the Pediatrician.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and resolve any outstanding balances in a timely manner.

Insurance: Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by your insurance. If the insurance company has not processed and paid the claim within 90 days, then payment of the account will become the responsibility of the parent/legal guardian. In the event of a separation/divorce, the parent bringing the child for the appointment is responsible for payment of the copay, which is due at the time service is rendered. If one parent specifically is responsible for medical bills, that parent must sign this form. If you sign this form, you will be held responsible for any amount owed and it will be your responsibility to collect from the other party.

Demographic Information & Insurance Cards: It is extremely important that we have updated demographic data from both parents so that we will be able to contact you in the future. We also must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing by your insurance and those claims would become your financial responsibility.

Network Providers: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify. You may contact our Business Office, if you have additional questions regarding network eligibility.

Co-Pays, Co-Insurances & Deductibles: I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. I understand that I am responsible for any balance not covered by my insurance.

Returned Checks: I understand that I will be charged an additional fee of $25 for any returned check.

Weekends/After Hours: I understand there is an additional fee for appointments on late evenings, weekends and holidays that may or may not be covered by my insurance.

Cancellation of Appointments: As a courtesy to other patients and the physicians, we require an advance notice prior to canceling appointments. You will be charged a fee if you fail to show up for a scheduled appointment and/or cancel a check-up appointment on the day of the visit.

Payment: We accept Cash, Check, Money Orders, Mastercard, Visa, American Express, Discover and Debit Cards for payment. You may be contacted by our office at any of your contact numbers listed to attempt to resolve any outstanding balances. In the event that the account is not resolved, I understand that my account may be turned over to a collection agency and my child/children will be terminated as patients of Pediatric & Adolescent Associates, PSC.

Assignment of Benefits/Authorization: As parent or legal guardian, I authorize payment of medical benefits to be made directly to Pediatric & Adolescent Associates, PSC for services rendered. I further agree to be fully responsible for all lawful debts incurred for services provided.

→	*Signature of Parent/Guarantor/Legal Guardian*	*Print Name*	*Date*

(Please list the name of every child)

Patient(s): _____

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