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| **Financial Policy**  We are pleased you have chosen our practice for your children. Please take a moment to read our financial and billing policy. We will be happy to answer any questions that you may have about this information.  If you do not have insurance, payment is due at the time of service. For your convenience, we accept Cash, Checks, MasterCard, Visa, and Discover. A $35.00 service fee is added for a returned check.  If you have insurance, please provide the staff with the **most current** insurance card and we will file your primary and secondary insurance. Co-pays required by your insurance are your contractual obligation and will be collected up front or you may be asked to reschedule your appointment. In most cases we will accept insurance assignment so that your insurance company will pay us directly. **Your insurance is a contract between you and your insurance company. You will be responsible for your account being paid in full either by you or the insurance company.** If your insurance does not make payment within 90 days or denies payment, you will be required to pay in full.  If you need to make monthly payments, a minimum of 10% of the balance is required each month. We do use a collection agency. If your account is sent to collections, your family’s care at our practice will be terminated. We realize that temporary financial problems may affect timely payment. Please contact the accounting department with any special circumstances.  In case of divorce, separation, or split families, each parent is equally responsible for the payment. Any legal agreement or other disagreement between parties must be dealt with those parties, we will not be involved in such matters.  **If a patient “No Shows” for an appointment without cancelling, they will be charged $25.00 fee. More than 3 “No Shows” may result in termination from practice**  If you have any questions, please feel free to call us at 402-489-0800.  **AUTHORIZATION:** I have read and understand the Financial Policy of Pediatrics, P.C. I understand that I am financially responsible for charges not covered or denied by my insurance and for all co-pays prior to services rendered. I authorize Pediatrics, P.C. to release any medical information needed to process claims and authorize payment of benefits to be paid directly to Pediatrics, P.C. I also agree to pay for the cost of collection, court costs, and other fees should they be required from nonpayment.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I consent for Pediatrics, P.C. to use PHI (Private Healthcare Information) of the child for TPO (Treatment, Payment and Health Care Operations).

I authorize and direct Pediatrics, P.C. to provide ongoing routine and emergency health care. This consent shall remain, in effect, until revoked in writing or the child turns the age of 19.

I understand a telephone consent may be obtained when treatment is needed and an adult is unable to accompany the patient at the time of services. Telephone Consents require a witness. Whenever possible, telephone consents should be followed up with a signature or fax.

Pediatrics, P.C. feels that wellness exams are very important to check on growth, development, nutrition, and to provide guidance for your child. If a concern arises during your child’s wellness exam, you may be asked to schedule a follow up appointment at a different time. Occasionally, circumstances may arise when extra time for problems may need to be performed at your wellness exam and not be rescheduled. Your insurance company may not pay for the extra time, so you may be charged for the non-covered services.

**Parent/ Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_