



South River Pediatrics, LLC

FINANCIAL POLICY

Childs Name _____

"We care for kids"

Thank you for choosing our office for your pediatric care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

The following is a statement of our financial policy, which we ask you to read and sign prior to any treatment. Your co-pay & deductible are payable in full at the time of service. To accommodate you, we will accept cash, checks, MasterCard & Visa.

Regarding Insurance

We will accept assignment of your insurance benefits. However, we do require your co-payment and deductible be paid in full at the time of the visit. The balance is your responsibility whether your insurance company pays for your treatment or not. We will gladly process your claims provided you give us accurate insurance information. It is your responsibility to inform us of changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to your contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable or necessary under the policy your employer has selected. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of service is provided. We will accept the "allowed amount" as it is stipulated in our contract with the insurance company. However, if a service is not covered, then it is your financial responsibility. We do not submit to secondary insurance.

MISSED APPOINTMENTS

Our policy is to charge for missed appointment at \$25.00 per visit. Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed with less than 24 hours notice are then unavailable to patients who need appointments. Please consider your schedule carefully when scheduling appointments.

OTHER FEES/CHARGES

Returned checks charge is \$25.00. Account balances older than 30 days are subject to additional collection fees and interest charges of 1.5% per month.

Thank you for taking the time to read and understand our financial policy. Our practice is committed to providing the best care for our patients. Please let us know if you have any questions. Any of our team members would be glad to review the financial policy with you at any time.

I have read the Financial Policy, I understand and agree to this Financial Policy.

Signature of Responsible Person

Date