

ABC Pediatrics
**Summary of Financial Policy
and Authorization**

Thank you for choosing ABC Pediatrics as the provider of your child(s) healthcare needs. Please read the following summary of our Financial Policy and sign where indicated. Ask for a copy of the ABC Pediatrics' detailed Financial Policy or see it on our website at www.myabcpediatrics.com

PAYMENT POLICY

We accept cash, check, and credit cards- American Express, MasterCard, Visa, and Discover.

INSURANCE

We agree to accept assignment for any insurance plan with which we are participating providers, and will file claims on your behalf. CO-PAYMENTS, any ESTIMATED CO-INSURANCE, or your DEDUCTIBLE are EXPECTED AND DUE AT THE TIME OF SERVICE.

Should you have no insurance coverage, payment is expected in full at the time of service. We do offer a payment plan, provided you have a qualified credit history, and have submitted your request in advance of treatment.

Charges are ultimately your responsibility. You have a contract with your insurance carrier, it is your responsibility to know your benefits, and we ask you to confer with your insurance company in the event of any dispute or issues with a claim.

DELINQUENT AND COLLECTION ACCOUNTS

Any unpaid delinquent debt, including no-show fees, owed to ABC Pediatrics will be referred to an outside collection service and will be reflected on your personal credit report.

You will be responsible for all additional expenses incurred by ABC Pediatrics in the course of obtaining payment, and the family on the account will be permanently dismissed from ABC Pediatrics.

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 my insurance.

I hereby authorize ABC 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 ABC 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 ABC 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's Signature

Date