FINANCIAL RESPONSIBILITY
Premier Pediatrics, Inc.

_____
Date

_____
Account Number

_____
Patient Name

I, _____, being over the age of 18 and by
Print name
Ohio law is legally responsible for any expenses billed by Premier Pediatrics, Inc.

By signing below I agree to take full financial responsibility for, and pay any balances incurred.

_____
Printed Name

_____ _____
Signature Date

FINANCIAL RESPONSIBILITY
Premier Pediatrics, Inc.

_____
Date

_____
Account Number

_____
Patient Name

I, _____, agree to take financial
Print name
responsibility for, and pay, any balances for my child

_____ who is over the age of 18 and by Ohio law
Print child's name

is legally responsible for any expenses billed by Premier Pediatrics, Inc.

_____ _____
Printed Name Relationship to patient

_____ _____
Signature Date

Premier Pediatrics, Inc. – Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Please initial on each line and sign at the bottom recognizing that you have read and agree to each line item

_____On arrival, please check in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

_____While the filing of insurance claims is a courtesy that we extend to our patients; **all charges not covered by your insurance company are your responsibility**.

_____According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances and any charges not covered by your plan.

_____It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.

_____If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.

_____If you have no insurance, payment for an office visit is to be paid at the time of the visit. There is also a $21 charge per vaccine if you are uninsured.

_____Co-payments are due at time of service. A **$5 service fee** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the business day.

_____Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. All **balances are due upon receipt** of your bill.

_____If previous arrangements have not been made with our billing office; any account balance outstanding greater than 30 days will be charged a $10 late fee. Any balance over 60 days will be forwarded to a collection agency. If forwarded to a collection agency you will be responsible for any and all collections fees assessed.

_____We require 24-hour notice for canceling any appointments. There is a **$75** charge for any appointment if it is not canceled OR if 24-hour notice is not given. You are responsible for this charge regardless of insurance.

_____A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

_____To copy or transfer medical records we charge **$2.73 per page for the first 10 pages; $.57 per page for pages 11-50; $0.23 per page for pages 51 and higher**. Ohio Law states that Premier Pediatrics has 30 days after the receipt of your request to provide you with your medical record.

_____If your child has school, camp, or sport forms to be completed, there is no charge for the first form. We have a 3 to 5 day turnaround time for all forms. If a form is needed sooner than 3 days, there is an additional **$10** rush fee.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date

PATIENT COPY

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- On arrival, please check in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
- While the filing of insurance claims is a courtesy that we extend to our patients; **all charges not covered by your insurance company are your responsibility**.
- According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances and any charges not covered by your plan.
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