Growing Kids Pediatrics, LLC

Patient Financial Agreement

- **Co-Payments** – Co-payments ae due at the time of service. If you are unable to remit co-payment amount, the office reserves the right to reschedule your appointment for another day/time that is convenient for you. If you wish to be seen at your regularly scheduled appointment the practice reserves the right to bill an additional $20.00 fee if the copay is not remitted by the end of the business day. _________ **(Initial)**
- **Prior Balances** – Prior balances are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment at the times of the scheduled appointment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the office reserves the right to reschedule your appointment for another day/time that is convenient for you. ______**(Initial)**
- **High Deductible Plans** – Due to the recent increase in high deductible plans, it is now the policy of Growing Kids Pediatrics to require a $50.00 pre-payment for any visit scheduled that is not for preventative care. Preventive care services include well visits, immunizations, and yearly wellness visits. ________**(Initial)**
    - Charges for all visits will be charged to your designated insurance carrier/provider for services rendered by Growing Kid Pediatrics. ________**(Initial)**
    - The $50.00 pre-payment will be applied to your account and any remaining balances, as determined by the insurance carrier will be billed to the responsible party on the account. _______**(Initial)**
- **Insurance Charges** – It is the responsibility of the patient/parent/guardian to notify the office of any changes to your insurance, so that we can correctly file claims, and accurately determine out of pocket cost. _______**(Initial)**
- **Billing** – Growing Kids Pediatrics bills insurance as a courtesy to our patients. If we receive denial information from your insurance payer, you may receive a bill from our offices. It is the responsibility of the patient/parent/guardian to reach out to our billing office and/or the insurance company to discuss the balance. ______**(Initial)**
- **Phone Calls** – Any phone number provided at which I may be contracted, I consent to receive calls or text messages, included but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. Calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication for the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collections agencies. _____**(Initial)**
- **Collections Activity** – If Growing Kids Pediatrics does not receive prompt payment, we reserve the right to transfer your balance to outside collections after 90 days. If an account is referred to outside collections, we reserve the right to dismiss the patient from the practice. _____**(Initial)**
- **No Show- There will be a charge for all no showed appointments. This includes arriving late and not being seen. We must have a 24 hour cancel notice for all Well Checkups or consult appointments or you will be charged $100. We must have a 3 hour cancel notice for all other appointments or a $50.00 fee will be charged. _______(Initial)**
- **Forms-** There is a $25 charge for all FMLA forms. Please allow 5 business days for completion. _____**(Initial)**

Your signature indicates your understanding and compliance with this policy.

Child(ren)'s Name:	DOB:
1.	
2.	
3.	
4.	

_______________________________________ _______________________________________

Print Guardian Name **Print Guardian Name**

(if patient is under 18 years of age) (if patient is under 18 years of age)