Financial Agreement

\_\_\_\_\_ I will inform Hartman Pediatrics of all primary and secondary insurance coverage policies

Including providing a current copy of all insurance cards at each visit.

\_\_\_\_\_ I will notify the office promptly of any insurance changes.

\_\_\_\_\_ Any balance not paid by the insurance will be the responsibility of the family.

\_\_\_\_\_ Copays and balances due must be paid at time of visit.

\_\_\_\_\_ Balances billed are due within 30 days. Balances can be paid by phone, on the patient

portal or in person by cash, check or credit card.

\_\_\_\_\_ Any outstanding balance past 30 days will have a late fee in the amount of $20 added

every 30 days. After 90 days, the account will be sent to collections and the family will be

asked to transfer care to another office. Collections fees will be added to the account in the amount of 50% of the balance.

\_\_\_\_\_ In order to simplify payments and avoid late fees, families do have the option to keep a

credit card on file for autopay with the office. If I choose this option, my card can be used

for copays at time of service or if a high deductible plan the card will be charged once

insurance has processed. If you would like to set this up, please ask at the front desk.

\_\_\_\_\_ Missed appointments will result in a charge of $40. Please notify the office as soon as

possible if you will not be able to make it to your appointment on time.

\_\_\_\_\_ More than 3 missed appointments per family may result in the family being asked to

transfer care to another office.

\_\_\_\_\_ Portal messages and after hours phone calls may be billed to insurance in certain

instances.

\_\_\_\_\_ A copy of the office HIPPA policy is available to me on the website or by paper copy at

my request.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_