Hartman
PEDIATRICS

Office Policies/Financial Agreement

_____ I will inform Hartman Pediatrics of all active insurance policies by providing a current copy of all insurance cards at each visit and will notify the office immediately of any changes. It is my responsibility to check with the insurance company to ensure Hartman Pediatrics is in network.

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

_____ Copays and outstanding balances due must be paid at time of the visit. Balances billed are due within 30 days. Balances can be paid by phone, on the patient portal, by mailing a check or cash in person.

_____ Balances past 30 days will have a late fee added every 30 days. After 90 days, the account will be sent to collections and the family will be asked to transfer care. Collections fees will be added to the account in the amount of 50% of the balance.

_____ Families are encouraged to securely keep a credit card on file for autopay.

_____ Missed appointments or cancellations with less than 24 hr notice will result in a charge of $50. 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 will result in the family being asked to transfer care.

_____ A forms fee will be charged for paperwork requested to be completed outside of the time of a visit.

_____ If we discuss a chronic condition or your child is sick at the time of a well exam, your insurance may charge a copay or deductible.

_____ Portal messages and after hours phone calls may be billed to insurance.

_____ I consent for Hartman Pediatrics and billing affiliates to communicate with me via portal, phone, text message, e-mail and other online communications compliance with privacy rules and regulations.

_____ As a patient of Hartman Pediatrics, I understand that preventive care is very important and agree to keep my child up to date on routine well exams including recommended screenings.

_____ I agree to treat the property of Hartman Pediatrics with respect while at the office and ensure my children do the same. I will be financially responsible for any damage to office property.

Patient Name: _____

Signature: _____Date:_____

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