



Patient Name: _____ DOB: _____

FINANCIAL POLICY

Thank you for selecting Pediatric Center of Round Rock for your healthcare needs. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, American Express, VISA, MasterCard, Discover. Please read and sign this financial policy prior to seeing the provider.

1. Your Insurance policy is a contract between you, (your employer), and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges". We are however, contracted with most insurance plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decided what a covered benefit is and what it is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment.
3. Co-payments not paid at the time of service are subject to a **\$10 processing fee**. All balances more than 60 days past due are subject to a penalty of **\$10 per month** to cover the cost of sending additional statements.
4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. **If your insurance company does not pay within 60 days, you will be responsible for payment.**
5. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party. If we are forced to send your account to collections, a **40% fee will be added to your balance.**
6. Please note that all cancellations must be at least 24 hours in advance, which allows us to care for other patient in need of our services. If you fail to cancel your appointment, you may be charged a **\$25 service fee** which will not be covered by your insurance plan.
7. There will be a **\$35 NSF** charge on all returned checks.
8. Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for us at a future visit. You may request a refund of overpayment by notifying our office.
9. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems with our office, so that we can assist you in management of your account with a payment plan.
10. All after-hours calls are subject to **\$20 fee**. The fee is intended to cover our costs, but not discourage you from calling if you are concerned about a sick child. Calls resulting in being referred to an emergency department by the physician/NP or an follow up office visit are exempt from the fee

GUARANTEE OF PAYMENT

I agree to be responsible for any amounts not paid by my insurance plan, excluding agreed-upon write-offs from any contracted insurance plans. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third -party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

AUTHORIZATION FOR CREDIT CARD ON FILE

I authorize Pediatric Center of Round Rock to keep my credit card on file. See Credit Card on File agreement.

PATIENT PAYMENT WITH CREDIT CARD ON FILE

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Pediatric Center of Round Rock may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than \$75, I will receive a courtesy call prior to my card being charged.

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of the practice's financial policy and agree to the terms of payment due.

Parent / Legal Guardian Name: _____

Signature of Parent / Legal Guardian: _____ Date: _____