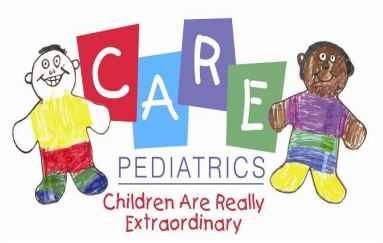

Financial Policy

Patient Name_____ **DOB**_____

Thank you for choosing C.A.R.E. Pediatrics, LLC as your child's primary care physician. We are committed to providing you with quality and affordable health care. Please understand that payment of the bill is considered part of your treatment. This Financial Responsibility Statement must be read and signed by the child's guardian prior to any treatment.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **In the event that your insurance company does not pay within 60 days, you will receive a bill from this office. You will be responsible for payment of this bill within 30 days of the date of the bill.**

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit***. Payments not received at the time of service shall incur a $25 administrative fee. THERE IS A $35.00 RETURN CHECK CHARGE FOR NSF CHECKS.***

3. Non-covered services. Please be aware that some services may not be covered by your insurance plan. Services including counseling for behavior problems, ADD, extended telephone conversations, and written correspondence. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients/parents and/or guardian's must complete our patient information form before seeing the doctor. We must obtain a copy of the parent/guardian's driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

6. Missed appointments. Our policy is to ***charge a $35 fee for missed appointments*** not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

7. Transferring Medical Records. Our policy is to charge a $20 fee to transfer medical records to any outside medical facility.

C.A.R.E. Pediatrics is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Noelle Ruddock-Solomon, MD 4855 River Green Parkway Suite 610 Duluth, GA 30096
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