Professional Pediatrics Financial Policy

Thank you for choosing Professional Pediatrics as your pediatric medical providers.
We are commited to maintaining the strong reputation we have developed for providing pediatric care in this area. In general, our office excels at seeing patients on schedule with shorter than average waiting room times. At times, we close to new patients to avoid overcrowding, to be able to offer same day appointments, and to maintain the ability to see patients on schedule in a non-rushed environment. It should be understood that, in order for us to maintain these advantages for you, our billing policies must be as efficient as possible.

Insurance

- We are providers for and accept most insurance company benefits. Our charges are consistent with what is reasonably charged by other medical offices in this area. Be aware that we are not responsible to know your insurance policy. Your insurance policy is a contract between you and your insurance company. Outstanding balances are your responsibility. If your insurance company has not paid your account within 60 days, the balance will be billed to you. Not all services are covered by all medical insurances. It is also your responsibility to ensure that your child is eligible by your insurance to be seen on the date of service.
- **We require your co-payment at the time of visit.**
- We do not bill secondary insurance.

In order for us to successfully bill your insurance company we need the following accurate information:

- Patient name and date of birth
- Subscriber name and date of birth
- Spouse name and date of birth
- PO Box AND Home Address
- Home phone number
- Place of employment and phone number
- Social security number of subscriber and spouse

Past Due Accounts

Account balances must be paid within 30 days of the date billed. Accounts 60 days past due will be considered delinquent and turned over to a collection agency. Patients with accounts more than 60 days past due will be discharged from Professional Pediatrics. Please help us serve you and your children by paying your account balances by the due date.

I have read the above Financial Policy. I understand and agree to these terms.

Date Patient Name

Name of Responsible Party Signature