



## Financial Policy Sheet

We are happy that you have chosen our practice to provide for your child's health care needs. We are committed to providing the best medical care and customer service available. As part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be happy to answer any questions you may have.

Our physicians participate with most major insurance plans. Due to constant coverage changes, we cannot guarantee that your insurance company will cover the services we provide. We will file your insurance as a courtesy. We will file your insurance for any services provided in the hospital. Should the services not be covered, you will be responsible for the bill. All bills are due and payable in full upon receipt of our statement.

           **It is the policy of your insurance company, and of this office, that all co-pays**  
**Initial** **be paid at the time of service. We cannot bill you for your co-pay.**

It is your responsibility to make certain that the physician your child is scheduled to see is on your insurance plan. Additionally, the parent that brings the child to the office is ultimately responsible for the bill.

Unless arrangements have been made in advance either by you, or by you having insurance coverage, payment for all services is due at the time of service. For your convenience we accept Visa, MasterCard, and Discover.

I have read, understand and agree to abide by the financial policy of the practice. I hereby authorize the release of any and all information necessary to process my insurance. I authorize my insurance company to pay directly to the physician any benefits due for services rendered.

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party

Witness: \_\_\_\_\_ Date \_\_\_\_\_