NORTH WILLOW GROVE PEDIATRICS, P.C.

Patient Name _____ **DOB** _____

I authorize the release of any medical information necessary to process the claim.

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding and assistance with our financial and payment policy.

Payment is required at the time of service. We accept cash, check or credit card (Visa or Mastercard).

For patients with *private* or *no insurance*, full payment is required at time of service.

For patients with **HMO plans,** co-payment is required at the time of service. The amount of co-payment varies with different plans.

While the filing of insurance claims is a courtesy that we extend to our patients, *all charges not covered by your insurance company are your responsibility.*

Evening and weekend appointments are billed to your insurance company with a surcharge. YOUR insurance plan may make YOU responsible for this service. The maximum that this fee would be to you is $25.00. Your insurance company can advise you if this is covered.

Well exams for children 3 years and older will include a **vision screening and hearing test.** They may not be covered by your insurance plan.

Vision screening	$ 30.00	Hearing test	$ 25.00

Behavioral and Developmental screenings may not be covered by your insurance.

Surveys	$ 25.00

Please contact your insurance company if you have questions about coverage of these services.

Bills unpaid for more than 90 days will be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

Missed appointments: Unless cancelled at least 24 hours in advance, there will be a $20 charge for missed appointments. Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in dismissal from the practice.

I have read the above Financial Policy. I have understood it and agree to it.

Signed:_____ **Date:**_____