## Pediatric Care North Office Financial Policy

**Patient Name**______________________________________________________________________________

**We would like to thank you for choosing Pediatric Care North as your child's and/or children's doctors. As our patients, we would like to keep you informed of our current office and financial policies.**

**PAYMENT:**

**Payment is required at the time services are rendered. This includes:**

- **Co-payments for participating insurances. Our contract with your insurance company states that we will collect a co-pay every time a patient presents to the office. If you disagree with this, please contact your insurance company for verification**
- **Non-covered services**
- **Un-Insured (Self-Pay) Visits**

**Not all services are a covered benefit in all contracts. If you have a question regarding benefits you will need to call your insurance company and check your benefits. This is not a responsibility of the physician's office.**

**Pediatric Care North accepts cash, personal checks, credit cards (Visa, Master Card, Discover and American Express). We are not a lending institution, and it is not our policy to extend credit. Patients with an outstanding balance more than 90 days overdue MUST make arrangements for payment PRIOR to scheduling appointments. We realize that financial difficulty is a reality, therefore our Billing Department is available to assist you Monday through Friday 8:00 am-4:30 pm at (816) 587-3341.**

**Accounts become past due after 60 days. We reserve the right to send an account to our collection agency, if the balance is not paid in full after 60 days. An additional collection fee of $36.00 may also be applied.**

**If your visit is due to a Motor Vehicle Accident (MVA), those services are expected to be paid within 30 days. It is not the physicians' responsibility to get involved with MVA's. Our office cannot wait on MVA settlements.**

**Know that the responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. This office will NOT get involved in court decisions.**

**Your appointment time is important to you, your doctor and to others who are in need of medical care. We reserve the right to charge for missed appointments. You will be personally responsible for this charge. This charge will not be billed to, nor paid for, by your insurance company. As always, emergencies and unforeseen circumstances are taken into consideration.**

**An additional fee of $30.00 will be applied to Evening and Saturday appointments.**

**I hereby acknowledge that I have read, and understand and agree to the terms of this financial policy.**

______________________________________________ **Date**________________________

**Parent's Signature**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**The Health Insurance Portability and Accountability Act (HIPPA) allows individuals to request restrictions on uses and disclosures of their protected health information. Further, the individual may request confidential communications to be made by alternative means.**

**Pediatric Care North has my permission to release protected health information to the following person(s).**

**1.**______________________________________________ **Relationship**________________________

**2.**______________________________________________ **Relationship**________________________

**SIGNATURE**____________________________ **DATE**______________ **RELATIONSHIP TO PATIENT(S)**__________________



Updated 6/18/13