PediaGroup Financial Policies

We at PediaGroup are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Parents/Guardians are **responsible** for all services provided at the time of the visit. This includes **co-pays, deductibles, co-insurance and non-covered services**. For your convenience, we accept credit cards, checks or cash.

We will file a claim to your primary insurance as a courtesy. However, you are responsible for any remaining balances. Any outstanding account over **60 days** must be settled prior to any future appointments. It is the parents/guardians responsibility to contact the insurance carrier to determine which charges may or may not be covered. An outstanding balance of more than **90 days** will be deemed delinquent and referred for collections.

Uninsured or non-contracted patients are responsible for payment-in-full at the time of service.

Returned checks for non-sufficient funds (NSF) will be billed an additional fee of $25.00.

Please be aware that if a significant health issue is addressed during a routine check-up or physical, this is a modified well visit and may result in a co-payment.

PediaGroup does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce or other arrangement places that obligation on former spouse.

Appointment cancellations are expected at least 24 hours prior to the appointment.

We reserve the right to charge for medical record copying services.

Authorization of Treatment, Release of Information and Assignment of Benefits:

I authorize the providers at PediaGroup Associates to treat my child. I further authorize the release any medical information necessary to process a related claim and request payment of benefit to the party who accepts assignment. I understand that I am financially responsible for any balance not covered by insurance. I hereby authorize PediaGroup Associates, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Signature of parent/Guardian: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

Patient(s) name: _____ Date of Birth _____

This policy may be subject to change