UTICA PEDIATRICS FINANCIAL POLICY

By signing below, I/We understand and agree too:

Provide correct insurance information and will make sure that the correct Primary Care Provider is listed with my insurance company. It is my responsibility to understand my coverage, benefits and limitations set forth by my insurance company. Please bring insurance cards to each appointment.

Payment will be collected at the time of the visit for all co-pays/balances due from the parent or guardian who accompanies the child, regardless of any financial/legal arrangements dictating who will pay.

A **$15.00 service charge** will be added to your account if the co-pay is not made at the time of service or within 24 hours. There will be an additional **$5.00 billing fee** added to my account every 30 days for failure to make payment or payment arrangements with the Billing office. (315-732-7909 Option #4).

I understand if my account is sent to collections then additional changes will be added to the balance. These include the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs we incur in such collection efforts.

If my child requires lab work that is sent to an outside lab, I understand that I will be billed separately by the lab.

I will be prompt for all appointments. Missed or cancelled appointments with less than 24 hour notice will result in: 1st time (per family) you will receive a reminder letter. 2nd and future missed appointments will incur a **$25.00 charge.** In addition, multiple missed appointments may result in the discontinuation of care by your physician.

I understand that in the event a check is returned for insufficient funds, a **service charge of $25.00** will be added to my account.

Financial hardship should never stand in the way of medical care. Since open communication can benefit both parties, any financial hardship should be discussed with the Billing office (315-732-7909 option #4) so that payment arrangement can be made as early as possible.

I HAVE READ, UNDERSTAND AND AGREE TO THESE TERMS AND CONDITIONS. I UNDERSTAND THAT FAILURE TO COMPLY WITH THESE TERMS MAY RESULT IN TERMINATION OF CARE FROM UTICA PEDIATRICS.

PATIENT _____ DOB PATIENT_____DOB

PATIENT_____DOB PATIENT_____DOB

PATIENT_____DOB PATIENT_____DOB

PARENT/GUARDIAN_____ DATE_____ (3/1/17)