GEORGETOWN PEDIATRICS, P.S.C.
FINANCIAL POLICY

Thank you for choosing Georgetown Pediatrics, PSC as your pediatric primary care provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients/guardians must complete this form prior to seeing the Pediatrician. We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and timely resolve any outstanding balances.

Insurance: We will be happy to process your insurance claims if you have an insurance policy that we participate with. **We must emphasize that our relationship is with you and not your insurance company**. All charges are your responsibility at the time of service (this excludes any amount due from your insurance company that we have agreed to accept payment from). Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by their insurance. **In the event of a separation/divorce, the parent bringing the child for the appointment is responsible for payment.** *Initials* ____

Demographic Information & Insurance Cards: It is extremely important that we have updated demographic data from both guardians so that we will be able to contact you in the future. We also must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to "timely filing" requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for "timely filing" by your insurance and those claims would become your financial responsibility. *Initials* _____

Network Providers: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify and contact our Business Office, if there are any questions regarding network eligibility.

Co-pays, Co-Insurances, Deductibles, HSA, HRA and Flexible Spending Accounts: I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. This also applies to HSA, HRA and Flexible Spending Accounts. We will collect up front an estimated allowable for the services provided. I understand that I am responsible for any balance not covered by my insurance. *Initials* _____

Returned Checks: I understand that I will be charged an additional fee of $20 for any returned check. *Initials* _____

Weekends/After Hours: I understand that there is an additional fee for appointments on late evenings, weekends and holidays that may or may not be covered by my insurance. *Initials* _____

Cancellation of Appointments: As a courtesy to other patients and the physicians, we require an advance notice prior to cancelling appointments. Please call us if you are unable to keep your appointment. There may be a fee for failure to notify us in advance. *Initials* _____

Payment: We accept Cash, Check, Money Orders, MasterCard, Visa, American Express, Discover and Debit Cards for payment. You may be contacted by our office at any of your contact numbers listed to attempt to resolve any outstanding balances. In the event that the account is not resolved, I understand that my account may be turned over to a collection agency and my child/children will be terminated as patients of Georgetown Pediatrics, PSC.
Initials ______

Assignment of Benefits/Authorization: As a parent or legal guardian, I hereby authorize payment of insurance benefits to be made directly to Georgetown Pediatrics, PSC for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered. *Initials* _____

________________________________ ________________________________ ________________

Signature of Parent or Legal Guardian Printed Name Date

Patient Name: ________________________________ Patient DOB: ________________ rev. 8/18/15