ACCT#

Orchard Pediatrics, PC

– Newborn through Adolescent Care –

FINANCIAL AGREEMENT

As a parent of a patient of Orchard Pediatrics, I authorize the physicians to examine, diagnose, and render all treatment as they deem necessary.

I understand that my insurance contract is between me, my employer, and the insurance company. We cannot guarantee payment of all claims. If my insurance company only pays a portion of the bill or rejects the claim, an explanation should be made available to the policyholder. Reductions or rejections do not relieve my financial obligation.

I have requested that Orchard Pediatrics bill my insurance company for covered services provided by the physicians on my child's behalf. I authorize payment directly to them. I understand that it is my responsibility to make sure that the bill is paid in a reasonable time. If, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

I further understand that in circumstances where parents / partners are separated or divorced that the parent who brings the child to the office is responsible for payment of the copay for that day, as well as, payment of the bill regardless of who is deemed financially responsible by the court. The physicians will not become involved in custody battles.

If I am unable to make a full payment of the patient balance for a previous service or balance from today's services, I will work with the billing department to create a payment agreement. A patient financial evaluation may be required to approve a payment agreement. If I have an unpaid delinquent account or have been sent to a collection agency, my children may be denied treatment if not medically necessary. I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

The payment methods accepted are cash, check, money order, Visa, MasterCard or Discover.

A returned check fee of $25.00 will be added for each check.

A service charge of $10.00 will be added if your copay is not paid within 7 business days from the date of service.

Our office will charge $25.00 for a no-show physical exam appointment that is not cancelled 24 hours prior to your child's appointment. More than 3 no-show appointments may result in termination of care for non-compliance.

A statement rebill fee of $10.00 will be added if no payment is received within the 30 day billing cycle.

Accounts will not be reduced or discounted.

Overpayments will be refunded to the appropriate party. Patient refunds will not be provided until all active and past due accounts are paid in full. Patient refunds of less than $5.00 will not be processed unless specifically requested.

I HEREBY CERTIFY, that I have read this form and I am satisfied that I understand its contents.

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PRINT NAME(S) OF PATIENT **DATE**

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PRINT NAME OF PARENT / RESPONSIBLE PARTY **SIGNATURE OF PARENT / RESPONSIBLE PARTY**