Today's Date _____/_____/______

Patient Name ______________________

INSURANCE / PAYMENT POLICY

Thank you for choosing our practice! First and foremost we are committed to the success of your medical treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of TLC Pediatrics, PLLC financial policies.

Please Realize:

1. Your insurance benefits are a contract between you, your employer and the insurance company.

2. Unfortunately not all services are covered by all insurance policies. Some companies select certain services that they will not cover. You may be billed for these services at a later time.

Although we participate with several insurance companies, insurance plans are complex and differ even within the same insurance company. It is your responsibility to fully understand your plan and make sure that our physician is in the plan network you select. It is also your responsibility to know your insurance benefits. We will file claims with your insurance for services provided in office however any co-payments, deductibles, co-insurance and non-covered services are the responsibility of the patient. All co-payments will be due on date of service.

Self Pay patients are required to pay the full amount at time of service, unless previous arrangements have been made with the billing department.

If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements. I understand that reasonable late fees or collection fees may be assessed in the event of late payment or nonpayment of balance. Failure to keep your account current may result in TLC Pediatrics being unable to provide additional services.

Administrative Fees: $25.00 additional charge may be added to your account for co-payment(s) not collected at the time of visit. *Returned Check Charge:* Non Sufficient Funds (NSF) checks are subject to a $12.00 fee (in addition to fees from your bank)

Divorce & Custody: TLC Pediatrics will not get involved in payment disputes between parents. The person who brings the child to the office will be expected to pay at the time of service and retrieve any payment from the responsible party.

We do not accept auto insuran ce as payment and we will not file claims to an auto insurance company.

I, ______________________, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due and referred to outside collections. I have read, understand, and agree to this Financial Policy.

Signature ____ Date ____________________________________

Printed Name ____

If you have any questions regarding this policy or any billing questions, please contact the billing department at 480-940-8527

A photocopy or scan of this acknowledgment shall be considered as effective and valid as the original