



## PATIENT FINANCIAL AGREEMENT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Co-Payments

Co-payments are due at the time of service. If you are unable to remit your co-payment amount, the office reserves the right to reschedule your appointment for another day/time that is convenient for you. If you wish to be seen at your regularly scheduled appointment the practice reserves the right to bill an additional \$20.00 fee if the copay is not remitted by the end of the business day.

### Prior Balances

Prior balances are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment at the time of the scheduled appointment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the office reserves the right to reschedule your appointment for another day/time that is convenient for you.

### High Deductible Health Plans

Due to the recent increase in high deductible plans, it is now the policy of One Pediatrics to require a \$50.00 pre-payment for any visit scheduled that is not for preventive care. Preventive care services include well visits, immunizations, and yearly wellness visits.

Charges for all visits will be charged to your designated insurance carrier/provider for services rendered by One Pediatrics providers.

The \$50.00 pre-payment will be applied to the account and any remaining balances, as determined by the insurance carrier will be billed to the responsible party on the account.

### Insurance Changes

It is the responsibility of the patient/parent/guardian to notify the office of any changes to your insurance, so that we can correctly file claims, and accurately determine out of pocket costs.

### Billing

One Pediatrics bills insurance as a courtesy to our patients. If we receive denial information from your insurance payer, you may receive a bill from our offices. It is the responsibility of the patient/parent/guardian to reach out to our billing office and/or the insurance company to discuss the balance.

Phone Calls

Any phone number provided at which I may be contacted, I consent to receive calls or text messages, included but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. Calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication for the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collections agencies.

Collections Activity

If One Pediatrics does not receive prompt payment, we reserve the right to transfer your balance to outside collections after 90 days. If an account is referred to outside collections, we reserve the right to dismiss the patient from the practice. The account is subject to additional fees related to the collections activity.

**Your signature indicates your understanding and compliance with this policy.**

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**Print Patient Name**

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**Patient Signature/Date**

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**Print Guardian Name**

(If patient is under 18 years of age)

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**Guardian Signature/Date**

(If patient is under 18 years of age)