

RMHC PEDIATRICS
Financial Policy

We are committed to providing you with the best care, and we are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

ALL PATIENTS MUST HAVE A COMPLETE “PATIENT REGISTRATION FORM”

- Full payment for services is **DUE AT THE TIME THE SERVICE IS RENDERED** unless other arrangements have been made with this office. We accept cash, personal checks, Visa, MasterCard, American Express and Discover.
- A \$25.00 fee is charged on all returned checks.
- Delinquent accounts may be referred to a collection agency. You agree that if it becomes necessary to forward your account to our collection agency, in addition to the amount owed; you will also be responsible to pay all reasonable attorney fees along with any additional court costs awarded by the court.
- If your account is sent to collection, your child will no longer be seen by any doctor in the office.
- **WE ARE NOT PARTY TO ANY LEGAL AGREEMENT BETWEEN DIVORCED OR SEPERATED PARENTS.**

INSURANCE PROGRAMS THAT CONTRACT DIRECTLY WITH US – YOU ARE RESPONSIBLE FOR UNDERSTANDING THE POLICY THAT YOU HAVE CHOSEN, and for providing our office with all necessary billing information. Please read the benefits of your individual policy. There are some services that may not be covered by your insurance – payment is expected at the time of service for non-covered charges. **COPAYMENTS ARE REQUIRED AT THE TIME OF SERVICE.**

INSURANCE PLANS THAT DO NOT CONTRACT DIRECTLY WITH US – YOU ARE EXPECTED TO PAY IN FULL FOR YOUR OFFICE VISIT. We will give you a receipt to submit to your insurance company for reimbursement. You are responsible for your bill regardless of an insurance claim.

I authorize the release of all medical records to my insurance and to any specialist for continuation of care, if applicable.

If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our billing office. This will avoid misunderstanding and enable you to keep your account in good standing.

I HAVE READ AND UNDERSTOOD THE ABOVE POLICIES AND I AGREE TO ACCEPT RESPONSIBILITY FOR ANY FINANCIAL OBLIGATIONS INCURRED.

Assignment of Insurance Benefits: I hereby authorize payment of medical benefits directly to RMHC Pediatrics. I further authorize the release of any medical information necessary for processing the insurance claim. I permit a copy of this authorization to be as valid as the original. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.

Permission to Treat a Minor (Under age 18): In the event of an emergency and I cannot be contacted, I give my permission to RMHC Pediatrics to treat my child in the office as required by the events emergency situation. I acknowledged that I have received and read the NOTICE OF PRIVACY POLICY AND PROCEDURES.

Signature

Date