



PATIENT NAME: _____ DOB: _____

FINANCIAL AND INSURANCE POLICY

- ✚ We participate in most insurance plans, including Medicaid, Amerigroup, Peachcare, Peachstate and Wellcare.
* * **Note:** We do *not* file to automobile, general liability or homeowner's insurance. * * *
- ✚ You and your insurance company are responsible for your bill.
 - Knowing your insurance benefits is ***your*** responsibility. (This includes, but not limited to, knowing if vaccines, wellchecks, labs or other procedures are covered or might fall under your deductible.)
- ✚ If your primary insurance company requires a co-payment, you ***MUST*** make the co-payment at the time of service.
 - Please remember that we are contractually obligated by your insurance company to collect your co-pay at the time of service.
 - The balance of your charges will be billed. Payment in full of patient portion will be expected with receipt of your statement.
 - *Co-pays do apply to follow up visits.*
- ✚ Proof of current, valid insurance must be provided at the time of service.
 - If you do not provide this information, you will be considered a self-pay patient.
 - Self-pay patients are required to make an advance payment on their office visit charge. The advance payment amount will be based on the services provided and due at the time of service.
 - You must report ***ALL*** insurance coverage. Failure to do so is consider insurance fraud. This will also result in full responsibility for the bill on *your* part.
- ✚ Appointments that are missed or not cancelled ***within 24 hours*** of the scheduled appointment time, will be charged a missed appointment fee of \$25.00 for sick visits and \$50.00 for Well and ADHD visits.
- ✚ Failure to receive your statement *does not* relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing and/or contact information.
- ✚ Past due accounts are subject to our collection process. There will be a **35%** collection fee on top of the balance due.
- ✚ Any returned checks are subject to a **\$30** return check fee.
 - Restitution must be made in cash, money order or credit card **ONLY**.

Printed Name of Parent or Legal Guardian

Date

Signature of Parent or Legal Guardian

Date