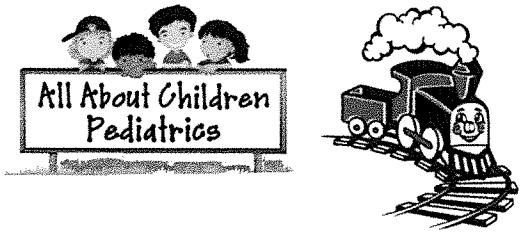

ALL ABOUT CHILDREN PEDIATRICS FINANCIAL POLICY:

According to your insurance plan, you are responsible for any and all co-pays, deductibles and co-insurances. Co-pays are due at the time of service.

We will ask for your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new group# etc.) since your last visit.

Insurance Companies can deny payment for services if they are not in your coverage plan. These services include but are not limited to:

- **After hours (late clinic)**
- **Hearing and Vision Services**
- **Saturday Hours**
- **Flu Vaccines**

In office procedures such as wart removal, frenectomy, removal of foreign body or ear wax, circumcision and sutures will be processed under the surgical guidelines of your insurance plan. It may be applied to your deductible with applicable coinsurance or may not be a covered benefit at all.

Self-pay patients are expected to pay for services in full at the time of the visit. This includes patients that we do not participate in their insurance plan. Our office will be happy to furnish a print out with all the necessary codes for you to file the claim for reimbursement with your insurance company for which we do not participate.

Patient balances are billed monthly and we ask that you pay your statement balance upon receipt of your first statement. **A $15.00 fee will be assessed on all unpaid balances 60 days after initial statement.**

If previous arrangements have not been made with our finance office, any account balance over 90 days old will be forwarded to a collection agency and all collectable expenses will become your responsibility.

We accept cash, check, and all major credit cards. **A $35 fee will be charged for any checks returned for insufficient funds and checks will no longer be permitted as a method of payment.**

AUTHORIZATION FOR PAYMENT:

I authorize payment of medical benefits to ALL ABOUT CHILDREN PEDIATRICS.

My signature below indicates that I have read, understand, and agree to the above terms. I hereby **authorize All About Children Pediatrics** to evaluate the person that I am legally responsible for or me (relationship listed below) for any illness or injury for which I seek medical care.

See back.....

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to **All About Children Pediatrics**. This assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Responsible Party: _____ Date: _____

Patient's Name: _____ Relationship: _____