ROSWELL PEDIATRIC CENTER, P.C.
FINANCIAL POLICY
(Patient over 18)

We are committed to providing you with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHARGES.

1. Our office participates with a variety of insurance plans.
   It is your responsibility to:
   - Bring your insurance card and photo I.D. at every visit.
   - Pay your Co-Payment and/or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept VISA, MasterCard, and Discover. We do not bill for Co-Payments.
   - Pay in full for any medical care or services that are not covered by your insurance plan.
2. If you have insurance that we do not participate with, or you do not have insurance, payment in full is expected at the time of service. You will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients, if the charges are paid at the time of service. Please see one of our front desk employees if you have any questions.
3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see you, but you will be "Private Pay" and required to pay at the time of service until the PCP has been changed to one of our physicians.
4. Secondary Insurance: We do not file secondary insurance. You may request a copy of the claim to file your child's secondary insurance yourself.
5. You are financially responsible for any amount not covered by your health insurance plan.
6. You are financially responsible for all charges incurred in your care and treatment.
7. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.
8. If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
9. To protect your records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Family Information Form. We will scan your insurance card, ID, and Family Information Form, into your electronic medical chart. We will check these documents prior to releasing your records. We will take a picture of you for your electronic chart. This photo helps us identify you during our routine operations. Your photo will not be released without your permission.

Late Arrival/No Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule to another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge you from the practice.
Missed or cancelled Appointment Policy: Check-up or Consultation appointments that are missed or not cancelled 24 hours prior to the scheduled appointment time, will be charged a missed appointment fee of $75.00.

Roswell Pediatric Center will not provide medical care to patients who refuse to sign and comply with our financial policy.

Signature of Understanding: I have read and understand the above stated financial policy.

____________________________ ________________________
Name Date of Birth

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Signature Date

ASSIGNMENT OF BENEFITS

I, the undersigned authorize payment of medical benefits to Roswell Pediatric Center, P.C., for any services furnished to me by the practice. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to ms. This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

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Signature Date