VALLEY PEDIATRIC ASSOCIATES, LLC

FINANCIAL POLICY

We would like to thank you for choosing Valley Pediatrics for your child's medical care. Valley Pediatrics believes that providing and maintaining a positive and communicative physician-patient relationship with our families is important. We want to make sure that you understand all of our financial policies relating to your responsibility and the responsibility of your insurance company. Please read this carefully. We will be happy to provide further clarification if needed. Please sign the Signature page to document that you have read and understood these policies.

BILLING / PAYMENT POLICY:

Payment is required at the time of service for all co-payments, deductibles and coinsurance, as dictated by your insurance company. There may be a fee for co-pays which have to be billed. Valley Pediatrics accepts cash, personal checks, VISA and MasterCard. There is a service charge of $35.00 for returned checks.

If you send your child to the office with another care giver (Grandparent, Nanny, etc.), please provide the caregiver with your insurance card and co-pay.

Patients with an outstanding balance over 90 days must make arrangements for payment prior to scheduling routine appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement. Payments are due within 30 days after denial by your insurance.

INSURANCE:

It is your responsibility to provide us with current insurance information and to present an active insurance card at each visit. Each insurance company may have several versions of coverage. It is your responsibility to fully understand your plan and any health savings accounts you may have. Valley Pediatrics is not responsible if your insurance does not pay, you are.

If your Plan requires, you must name Valley Pediatrics as your Primary Care Doctor prior to your first appointment. If a Valley Pediatrics physician is not named on your insurance as your Primary Care Doctor, your appointment may need to be rescheduled.

You must receive a referral to specialists *before* the appointment. As per your insurance rules, no retroactive referrals will be given.

FORMS:

There is a fee for forms that is due at the time a form is dropped off. Please see the Form Fee Explanation for further details.

CANCELED APPOINTMENTS:
If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge for appointments that are not cancelled at least 24 hours in advance. ($25.00 for sick visits, $50. 00 for Well-visits) This fee is usually not paid by insurance.

PAST DUE ACCOUNTS:
If we have to turn your account over to collections, you agree to pay 10% interest on the outstanding balance from the date your bill was due, and all our costs and expenses of collection, including, but not limited to, our reasonable attorneys' fees.

QUESTIONS ABOUT THE BILL:
Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent a child from receiving the care they need at the time they need it. However, if you ignore or fail to respond to your financial obligation, we reserve the right to discharge you from our practice. If payment is not received or arrangements made, we will assume you no longer want to have your children seen at Valley Pediatrics. Your account may be sent to collection and all legal fees and collection expenses will be added to your balance. By law, we will continue to provide emergency care for 30 days from the date of notice of your discharge from the practice.

SIGNATURE SHEET

____ _______________________

Patient's Name Date of Birth

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Patient's Name Date of Birth

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Patient's Name Date of Birth

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Patient's Name Date of Birth

Financial Policy

I have read, understand, and agree to the Financial Policy of Valley Pediatric Associates, LLC, dated 2/10/2016

X ____ Date: ____________________

Parent / Guarantor

Assignment of Benefits

I hereby authorize any physician of Valley Pediatric Associates, LLC, to apply for benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to such physicians. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. A copy of this authorization may be used in place of the original.

X ____ Date:____________________

Parent / Guarantor

Consent to Treat

I (or my legal guardian or parent) authorizes Valley Pediatric Associates, LLC, to provide medical care reasonable by today's standards.

X ____ Date: ____________________

Parent / Guarantor

HIPPA / RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Valley Pediatric Associates, LLC, Notice of Privacy Practice, which provides information about how we may use and disclose your protected health information.

X ____ Date: ____________________

Parent / Guarantor