OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are ready to discuss our professional fees with you at any time. Your understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or what your responsibility is.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DEBIT CARDS.

  There will be a charge for returned checks.

- MINORS WHO ARE SEEN IN OUR OFFICE

  An adult must accompany all minors. If your child has a drivers licences and you desire them to come to a sick appointment alone, please call ahead for approval. Payment will be due at the time of service.

- REGARDING BILLING

  Billing statements to be mailed to the child'sp rimary residence. We cannot hold checks. If you have an emergency or a problem paying please call our billing department and they will discuss arrangements with you. **Late fees will also be assessed on accounts 30 days past due.**

- REGARDING INSURANCE

  If we accept your insurance, you are responsible for any deductibles, coinsurance or copays at the time of service. Insurance policies with required copays must be paid at the time of service or we may charge YOU for the full amount of the visit. If your insurance carrier changes, it is your responsibility to notify us when checking in. If you fail to do so, you may then become responsible for the full amount of the visit. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

We do not get involved in Divorce settlement/financial responsibility. That is to be worked out between parents.

Island Pediatrics charges a fee for no show appointments as well as appointments not cancelled 24 hours in advance.

I understand and agree that, regardless of my insurance status I am responsible for any professional services rendered not covered by insurance. I understand and agree that if I fail to make prompt and timely payments to Island Pediatrics, I will be directly responsible for any and all cost of collections.

I have read all of the information above and understand it to the best of my knowledge.

Signature of Parent/Guardian ________________________________ Date______________