FINANCIAL AND OFFICE POLICY

Premier Pediatrics of Sumter, LLC

380 W Wesmark Blvd, Bldg B, Sumter, SC 29150
Office: (803) 607-9430 Fax: (803) 607-9431

Initial_____**INSURANCE PLANS**: I understand it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen under "out of network" benefits.

Initial_____**NO INSURANCE AT THE TIME OF SERVICE**: If proof of insurance coverage cannot be determined at the time of service, I understand that payment is required at the time of services and I will not be billed.

Initial_____**COVERAGE**: I acknowledge that Premier Pediatrics is not responsible for knowing what services my insurance covers. I shall direct questions regarding health insurance policy coverage to my insurance company.

Initial_____**FINANCIAL COMMITMENT**: I agree to be responsible for all copays, deductibles, and non-covered services determined by my insurance plan at the time of my visit. If I do not have a copay or have not come prepared to pay past due balances, my child's appointment may be rescheduled for a later time. **Furthermore, I understand that if someone other than me is bringing my child to Premier Pediatrics, they will be responsible to pay for copays and past due balances.**

Initial_____**PAYMENTS**: I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. Any balance remaining after my health insurance processes a claim is my responsibility. If I have not paid my bill or have not arranged for a payment plan, I authorize Premier Pediatrics to process my credit card on file.

Initial_____**LATE FEE**: I understand my account will be charged $5 per month on 30 day past due balances.

Initial_____**SERVICE FEE**: I understand my account will be charged $30 for NSF/Returned checks.

Initial_____**APPOINTMENTS AND LATE ARRIVALS**: I understand that it is important to arrive on time for my appointment. I'm also aware that if I arrive more than 20 minutes past my scheduled appointment time, the practice may have to reschedule my appointment.

Initial_____**NO SHOWS**: I commit to give Premier Pediatrics at least 24 hours' notice if I am unable to keep my scheduled appointment. I understand that Premier Pediatrics does not charge for missed appointments; however, if I miss 3 appointments without notifying the practice within a 12-month period, the practice will no longer be able to continue providing pediatric healthcare services. I understand that I will be dismissed from the practice.

Initial_____**MINORS**: If a legal guardian does not accompany my child, I agree to provide written authorization for medical treatment so that treatment can be rendered. I also agree to be available by telephone in the event that the physician needs to contact me.

Initial_____**DEMOGRAPHIC VERIFICATION**: I am aware that I will be asked to verify insurance and demographic information so records remain current.

I have read, understood and agree to the above financial and office policy. **I understand that Non-compliance with this policy may result is a dismissal from Premier Pediatrics.**

Parent / Guarantee's Signature_____ Date:_____

Print Name: _____