DECATUR PEDIATRIC GROUP, P.A.

FINANCIAL RESPONSIBILTY STATEMENT

Please read carefully!

Thank you for choosing Decatur Pediatric Group as your child's health care providers. We are committed to successfully managing your child's health. Please understand that payment of the bill is considered part of your treatment. This Financial Responsibility Statement must be read and signed by the child's guardian prior to any treatment. All patients should also complete our Patient Information and Insurance form before seeing the doctor. Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns.

While we do participate with many insurance plans, accounts covered by other plans must be paid in full at the time of service unless prior arrangements have been made. We accept Cash, Checks with prior approval and MasterCard, Visa, Discover or American Express.

Insurance: We will be happy to file insurance claims for you, as a participating provider in your plan. We cannot file any claims without a copy of the insurance card. If your insurance company requires you to choose a PCP, Decatur Pediatric Group or provider's name must be on the card. Please present your insurance card at each visit. You are responsible for knowing what your insurance company covers. Plans can differ, even within the same insurance company. Please be aware that some, and perhaps all services provided may be non-covered services and not considered reasonable and customary under your insurance plan, such as counseling for behavior or learning problems, ADHD, ADD, extended telephone conversations, and written correspondence. You may be billed for these services directly. Should your insurance carrier require you to use a specific lab or other outside facility, it is **your** responsibility to **inform the nurse.** Failure to do so may result in charges to you, which your insurance company does not cover. The balance of any claim filed to your insurance is your responsibility. **In the event that your insurance company does not pay within 60 days, you will receive a bill from this office. You will be responsible for payment of this bill within 30 days.**

Co-Payments: Some insurance companies require a co-payment for **each and every office visit regardless of the services being performed**. All co-payments are due at check-in, prior to treatment.

Referrals: Please be aware that some plans require pre-authorization before seeing a specialist. If you choose to see the specialist BEFORE receiving approval, you may be required to pay out of pocket. If you must take your child to an urgent care facility after hours or on weekends, please contact our referral department at extension 529 on the next business day so we may process a referral for you.

Missed Appointments: All visits are by appointments only. There is a $25.00 administrative fee for all missed appointments and appointments cancelled less than 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

I have read and understand the Financial Responsibility Statement. I agree to these conditions.

X_____Date:_____

Signature of Responsible Party

Please list all children (with first and last names) and their birthdays:

_____

_____