HARRISON PEDIATRICS
FINANCIAL AGREEMENT

Thank you for selecting **HARRISON PEDIATRICS** for your medical care. In order to prevent any misunderstandings concerning the responsibility regarding payment for any care, the following information is provided:

It is important for you to consult with your insurance and our billing personnel prior to your visit to determine which services are covered.
If for any reason you are unable to meet your obligation, please feel free to contact our billing office. **We are here to help you.**

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

APPOINTMENTS – 24 hours notice must be provided in the event you cannot keep an appointment for a follow up visit and Physicals only.

REFERRALS – If your plan requires a referral we need at least 48 hours notice.

CO-PAYMENTS – By Law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered and co-pays, Harrison Pediatrics will not be involved with separation or divorce disputes.

ACKNOWLEDGEMENT

I have read, understand and agree to the above financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I understand that if I do not utilize participating physician, no coverage or only out-of-network coverage will be available from my provider for such services and that I will be solely responsible for all payments related to same. I also understand that in the event of nonpayment or partial payment from my insurance company, I am responsible for any unpaid balance in the event of litigation, I will be responsible for all costs of suit including, but not limited to, court costs, collection fees and reasonable attorney fees.

I authorize insurance benefits payable to me or my assignee to be paid directly to **HARRISON PEDIATRICS LLC.**

I authorize **HARRISON PEDIATRICS** to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

WE ACCEPT CASH, CHECKS, MASTERCARD, AND VISA.
Thank You for taking the time to review our policies. Please feel free to ask any questions.

Patient's Name:_____ **DOB:**_____

Responsible Party signature _____ **Date:**_____

Print Name:_____ **Relationship**_____

Revised 1/09