Patient Name: ______________________________DOB:________________ Acct#:__________________________

Patient Financial Responsibility Policy Statement:
Pediatricz Now is pleased to provide your children, our patient, with the highest level of care for your child's health and quality of life. We strive to employ the most professional staff and deliver services to you with the latest technology and education available each day. You and Pediatricz Now, together, will combine our energies to bring positive results to your child's healthcare needs. Pediatricz Now in its continuous efforts to deliver the best in care requires payment of all known patient responsible balances at time of service. These balances may include but are not limited to co-pays, deductibles or co-insurance. (amounts as stated in the benefits coverage contact with your insurance carrier); any amounts due for patients who are "self-pay"; any amounts due from previous dates of service, or amounts that may be incurred during your current visit. We understand that circumstances may preclude you from paying amounts due at time of service. In this event, arrangements may be made to work out a payment plan with our billing office. We appreciate your understating and cooperating to ensure that Pediatricz Now is able to continue its provision of the highest level of services to all in need of our staff and facilities.

Payment Policy:
Payment is expected at time of service for any applicable co-pay, co-insurance, and/ or deductible. Pediatricz Now accepts cash, Visa, Mastercard, or American Express as forms of payment for your convenience.

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(Initials)

Insurance Policy:
We will require a copy of your insurance card and driver's license at the time of your arrival. Pediatricz Now will bill your insurance company as a courtesy to you, but this billing service does not preclude your financial responsibility for the services received. Any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. Please understand that your insurance policy is a contract between you, your employer and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. If Pediatricz Now is not contracted with your insurance provider, Pedatricz Now, as a courtesy, will submit claims to your carrier, any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. Pedatricz Now will mail monthly statements and contact you to collect any open balances. Please inform our staff immediately of any insurance changes.

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(Initials)

Non-Covered Service Policy:
Certain services performed by our office, for your child's benefit, may **NOT BE COVERED** by your insurance plan(s). We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility.

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(Initials)

Delinquent Accounts Policy:
Delinquent accounts will be reported to our collections department if a claim is unpaid after 90 days from the date of service following Pedatricz Now normal collection procedures to resolve any outstanding balances. Please inform our billing staff if you know your payment will be late in arriving or if you require payment arrangements. In the event of an overpayment we will reimburse you or your insurance company at the end of the following month that the overpayment occurred. Any balance over 120 days will be sent to a collection agency unless arrangements have been made prior to the due date.

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(Initials)

Medical Records:
Should you request a copy of your medical records or financial statements please allow our office 7-10 business days for completion. The charge of this service is five dollars ($5.00) pages 1-5, then one dollar ($1.00) for each additional page.

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(Initials)

Forms Policy:
Should you request our office to complete forms on your child's behalf such as immunization records, disability forms, daycare, etc, there will be a charge of five dollars ($5.00) per form. Payment of this charge us expected at time of completion.

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(Initials)

Urgent Care hours/After hours Policy:
Our urgent care hours are Monday-Saturday 10am-10pm and Sunday 10am-6pm. For emergencies occurring after hours, dial 911 or go to the nearest emergency room.
Appointments/Cancellations/No Shows/Reschedules:
A parent or legal guardian must accompany all minor patients. We understand unusual circumstances may arise, please contact our office as soon as possible with any changes with appointments. Appointments are welcomed but subject to change depending on urgent care capacity and walk-ins.

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(Initials)

Effective: 9/13/2021

By signing below, I hereby declare I am the parent/guardian for the child listed above. I have read and understood all office policies and take full responsibility for all of my child's medical and financial obligations.

The signed authorization is good for the life of treatment with Pedatricz Now or until the patient reaches 21 years of age.

________________________________ DOB ____________ Date ______________
(Patient Printed Name)

________________________________ ____________________________ Date ______________
(Parent/Guarantor Printed Name) (Parent/Guarantor Signature)

Reviewed by:________________________ Date ________________