Azalea Pediatrics

6801 River Road, Suite 401 | Columbus, GA 31904 | 762.208.5025
www.azaleapediatrics.com

Financial Policy

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If your insurance company denies coverage, or we otherwise do not receive payment 90 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Copayments and Deductibles:
Depending on your insurance policy, a copayment and/or deductible or coinsurance may be required at the time of service. Payment may be made in cash, by check or by credit card.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. Coinsurance may apply even after meeting your deductible.

Patients Without Insurance Coverage/Non-covered expenses:
We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time-of-service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit. The same discount will be applied to any non- covered charges for patients with insurance, if paid at the time of service. This discount cannot be applied toward the "patient responsibility" portion of covered charges, as those charges are already discounted through the contract we maintain with your insurer.

Financial Arrangements:
Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (Returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Patient/Parent/Guardian Responsibility:

- I understand that whomever accompanies my child to their appointment has authorization to consent to medical care as needed, *and is responsible for payment of medical services.*
- I acknowledge my responsibility for payment of all services provided by Azalea Pediatrics in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Late Fees:
I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:
I authorize payment to be made directly to Azalea Pediatrics by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Name (please print): **Date:**

Patient's Name and Birth Date:

Signature of Responsible Party (Guarantor):

Relationship to Patient(s) (please check): **Parent** **Self** **Other:**

Witness Signature:

Note: *The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.*

Notice of Privacy Practices Written Agreement:

I also acknowledge that I have read a copy of Azalea Pediatrics' Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Azalea Pediatrics has a link to the Notice of Privacy Practices on the practice website.

Name (please print): **Date:**

Signature of Parent / Guardian / Patient: