FINANCIAL POLICY DISCLOSURE AND AGREEMENT

Patient Name:___________________________________ **Date of Birth**:________________________

Thank you for selecting Sunshine Pediatrics, LLC for your pediatric healthcare needs. The financial policies discussed here help us protect our ability to successfully provide care while responsibly adhering to the guidelines mandated by those health insurance companies with which you and this Practice have contracted. Your clear understanding of our financial policies and your willingness to comply is important to our professional relationship.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE PRIOR TO SEEING A PROVIDER: Sunshine Pediatrics collects co-pays and any outstanding balances prior to your being seen by the provider. All co-pays, deductibles, co-insurance, and non-covered services must be paid at the time of service as required by your insurance company and our contracts with them. Any outstanding patient responsible balances are expected to be paid in full unless other arrangements have been made in advance.

In accordance with the signed Credit/Debit Card Payment Authorization Form, you authorize charges to your credit/debit card for payment of any amounts due to Sunshine Pediatrics for its medical services that have not otherwise been satisfactorily paid.

INSURANCE: We will ask to verify your insurance coverage and benefits, and you must present a currently valid commercial or medical assistance insurance card at each and every visit.

Dr. Clark **must** be designated as your child's primary care physician ("PCP") with your insurance company prior to being seen by Dr. Clark. If she is not formally designated as the PCP, we cannot file your insurance claim and you will be personally responsible for the full amount of charges for the visit at the time of service.

We bill participating insurance companies as a courtesy to you, but ultimately you are responsible for all charges for medical services including, as mentioned above, co-pays, coinsurance and deductibles. You must supply and authorize the release of all information that the practice and/or your insurance company deems necessary for the accurate billing and processing of claims filed on your behalf, and/or to obtain precertification for services. If we have not received payment from your insurance company within 60 days of the date of service, you are expected to pay the balance in full. We will supply you

with a copy of your itemized billing statement so that you can seek reimbursement from the insurance company.

ASSIGNMENT OF INSURANCE CLAIMS: You authorize payment from your insurance company directly to Sunshine Pediatrics or Dr. Maiya Clark, and understand that you are personably responsible for any and all usual and customary medical charges not paid as a result of this assignment, or which are not otherwise covered under your policy.

REFERRAL TO COLLECTION AGENCY: Any outstanding balance that is the responsibility of the patient or guarantor that is 60 days past due may be forwarded to a collection agency. The patient and/or guarantor debtor will be responsible for any costs incurred by the practice with the collection agency in addition to the balance due.

MISSED APPOINTMENTS AND LATE CANCELLATIONS: Missed appointments and untimely cancellations represent a cost to the practice, to you and to other patients who could have been seen during the time set aside for you. Cancellations **must** be made no later than 24 hours prior to the appointment. We will assess a $35.00 charge for missed appointments or appointments not cancelled within 24 hours. Any excessive abuse of scheduled appointments will result in discharge from the practice.

PARENTAL/GUARDIAN SEPARATION OR DIVORCE: Sunshine Pediatrics does not get involved in disputes between separated or divorced parents/guardians and the particulars of their legal agreements regarding financial responsibility for their child's medical expenses. The person who brings the child in for treatment is the person responsible for the charges. We will provide a receipt so that the party paying for the services can seek reimbursement from the other parent/guardian. We will not bill third parties for payment of the balance due.

Self Pay Patients: Full payment is due at the time of service unless an alternate financial arrangement has been made in advance. Under the "Pay out of Pocket" provision in HIPPA, an otherwise insured patient has the right to pay out of pocket and not have the services reported to his insurance company on a case by case/date of service basis. We cannot, however, submit some of the service charges to insurance and accept payment out of pocket for other portions of service on the same date.

REFUNDS: Any overpayments on a patient account will be refunded within 30 days of the time it is determined by the insurance company and offset by any prior outstanding balances.

FORM FEES: Please see our website (www.clarkmdpeds.com) for fees associated with forms.

I HAVE READ, AGREE AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THIS FINANCIAL POLICY, AND I ACKNOWLEDGE PERSONAL RESPONSIBILITY FOR PAYMENT OF THIS ACCOUNT.

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SIGNATURE OF RESPONSIBLE PARENT/GUARANTOR/GUARDIAN **DATE**

PRINTED NAME:______________________________________ **EMAIL:**____________________________