Pediatric Partners, PLC
4649 N Breton Ct SE, Suite A
Kentwood, MI 49508

# FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you treatment in the best possible manner. Please understand that payment of your bill is expected at the time of service. The following is a statement of our Financial Policy.

- **CO-PAYS ARE DUE AT THE TIME OF SERVICE**
- **WE ACCEPT CASH, CHECK, MONEY ORDER, VISA, DISCOVER, AND MASTERCARD**
- **INSURANCE BILLING**
  It is our policy to bill your insurance company for you. However, we need your assistance in keeping us updated regarding any changes to your insurance information. Your policy is a contract between you and your insurance company. We are not a party to that contract and do not set the terms of your coverage. You will be responsible for any charges that are not covered by your insurance.
- **ACCEPTING ASSIGNMENT**
  We will accept assignment of benefits from your insurance company. This means that benefits payable for the services provided by Pediatric Partners, PLC will be paid directly to the provider of service. This does not mean you will never have a balance due, it means that we charge what the insurance indicates. You may owe co-pays, deductibles, and/or co-insurance on your services.
- **NO INSURANCE / NO CARD / WRONG PCP / SELF REFERRAL**
  For patients with no insurance, no insurance card with them, the incorrect PCP listed on the insurance card, or no prior authorization (if necessary), please understand that your insurance may not pay for the services provided to them by Pediatric Partners, PLC. You will be responsible for the full amount of our charges.
  In addition to this policy, I understand that if I present false or fraudulent insurance information at the time of my appointment(s), Pediatric Partners, PLC reserves the right to immediately discharge the patient from our practice.
- **OUT OF NETWORK VISITS and NON-PARTICIPATING PROVIDER STATUS**
  If we are not contracted as a participating provider with your insurance company, please be aware that you are responsible for the portion of the bill not covered by insurance, regardless of any insurance company's arbitrary determination of usual and customary rates. We are not obligated to discount our fee to the insurance company's determination of reasonable and customary if we are not a contracted participating provider with that insurance plan.

I have read this Policy. I understand and agree to this Policy.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of Parent or Responsible Party Date