

# Jacksonville Pediatrics

## Our Financial Policy

We are committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship.

\*\*\* Full payment is due at the time of service.

\*\*\* We accept cash, VISA, MasterCard, Discover, American Express and ATMS.

\*\*\* All patients must be accompanied by an adult at every visit.

\*\*\* Billing \*\*\* It is the policy of this office not to bill or extend credit. You are required to pay at the time of service.

\*\*\* Insurance \*\*\* We accept most insurance plans, however, you are responsible for any deductibles, coinsurance, or copays at the time of service. You are responsible for the bill in full if no payment is received within thirty (30) days. You are responsible to notify the office of any insurance change. Failure to bill an insurance company in a timely manner can result in non-payment and will be due from you in full. Insurance coverage is a contract between you and your insurance company, we therefore do not get involved with any disputes between you and them. Our office only bills primary insurance coverage.

\*\*\* Return Check \*\*\* All return checks are automatically sent to our collection agency. You will receive notification from them promptly, we do not redeposit checks.

\*\*\* Responsible Party \*\*\* The guardian whom brings the child in the office is responsible for payment. Divorce settlements/financial responsibility issues must be settled between the parents. We do not get involved in these issues.

\*\*\* Missed appointments \*\*\* There will be a \$25.00 charge for all missed appointments not cancelled within 24 hours.

\*\*\* Copies Request \*\*\* Everyone receives a receipt upon checking out, therefore there is a \$5.00 charge for each receipt copy request.

\*\*\* Collections \*\*\* If at anytime your account requires outside collection efforts, you will be responsible for your balance plus all fees from the collection agency.

\*\*\* I understand and agree that, regardless of my insurance status, I am responsible for my account. I have read all the information on this sheet and understand it to the best of my knowledge.

Signature of  
Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_