PC PEDIATRIC CARE OF ROCKVILLE, P.A.

Financial Policy

Patient Name_____ Date of Birth_____

The following **ACKNOWLEDGEMENT FOR THE POLICIES OUTLINED BELOW WILL NOT EXCUSE THE GUARANTOR FROM ACCOUNTABILITY.*** Please read carefully:

- I understand that I must provide a current insurance card at **EVERY** visit.
- I understand that I must confirm contact information at **EVERY** visit.
- I understand that my insurance policy may not cover every service provided and that I am financially responsible for any services that were not covered by my insurance.
- I understand that I am responsible for any balance (copays, deductibles, coinsurance, and/or non-covered services) left unpaid by my insurance.
- I understand that I have **30 days** from date of birth, to add my newborn(s) to my insurance policy. After 30 days, each visit will be considered self-pay.
- I understand that I must provide 24 hour notice of any appointment cancellations.
- There will be a **$50.00** charge for all missed appointments for physicals, preoperative or medication recheck.
- There will be a **$25.00** charge for all missed appointments or any sick visits that are not cancelled before appointment time.
- I understand that I will be charged **$35.00** for a returned check and that I will be required to use cash or credit card to make future payments.
- I understand that any balance left unpaid for 90 days, will be considered for **collections** IF I have not responded to any attempts made to contact me for payment by Pediatric Care of Rockville, P.A.
- I declare that the signature on this policy is mine and I acknowledge that I cannot sign someone else's name on their behalf.

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Patient/Guarantor Name (PRINTED)

_____ _____

Patient/Guarantor Signature Date