

Lake Shore Pediatrics, Ltd.

Financial Policy

We are committed to provide your child(ren) with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

This is an agreement between Lake Shore Pediatrics Ltd., as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Lake Shore Pediatrics Ltd. By executing this agreement, you are agreeing to pay for all services that are received.

Payments: If you have a balance on your account, you will receive a statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days. Some insurance companies select certain services they will not cover, such as well-care visits or immunizations. Please be aware of such exclusions, as you will be responsible for these items. Should your account balance be \$150.00 or more, we will deny immunizations and labs for physical examination appointments. We will make an effort to notify you of this balance prior to your appointment so that payment can be made.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we will not bill you. We also have a walk-in fee of \$20, payable at the time of visit, should you come to the office with your child without a scheduled appointment. This is also non-billable to your insurance company. Medications obtained in our office must be paid for at the time of visit. We will provide you with a receipt that you can mail to your insurance company. Should you become delinquent on your account repeatedly, we may ask to have a credit card on file for future balances. We will not file a lien with an auto insurance or attorney for services rendered due to a car accident. We also cannot bill your medical insurance for these charges. We expect payment at the time of service. We will provide you with a detailed receipt. We can keep your credit card authorization on file for any patient balance due. Please place your cc# at the end of this policy.**

If you have no insurance, payment is due at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. It is your responsibility to know the benefits of your insurance. We are not privy to this information. We will bill your primary insurance company if we are preferred providers for all charges generated, including physician phone calls. You agree to pay any portion of the charges not covered by insurance. No discounts will be taken from the original amount charged, other than what is required by our contractual agreement with your insurance company. It is your responsibility to make sure our office has the correct insurance information in your account. Most insurance companies have timely filing issues. Should you fail to provide this office with current insurance information, and your insurance company denies your claim due to timely filing issues, the charges will then become your financial responsibility. Please advise us of any changes immediately. Please do not ask us to change procedure codes to accommodate your insurance company. This is fraud. **Should you belong to a contracted POS or HMO plan, our physician's name or Lake Shore Pediatrics must appear on your child's insurance card or you will be required to pay at the time services are rendered. Failure to present a current**

(over)

insurance card at the time of visit could result in either rescheduling a physical visit or paying at the time of service.

Practice information forms: Parents refusing to fill out forms completely will be required to pay at the time of service. If your insurance company requires your social security number for claims, please provide it – we only use this information for collection purposes or to file insurance claims.

Missed appointment fee: Patients who fail to keep a physical exam appointment, or cancel with less than 24 hours notice, will be charged a \$35 fee. This fee must be paid before a new appointment is scheduled.

Past due accounts: We will ask for any patient due balance at your visit. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency your child(ren) will be dismissed from our practice. Also, should you file for bankruptcy your child(ren) will be dismissed from our practice.

Waiver of confidentiality: You understand if this account is submitted to a collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce/separation, the parent or legal guardian who brings the child to the office is the person responsible for the charges. We will not become involved with the particulars of your divorce/separation.

Transferring of Records: You will need to fill out our records release form, and pay a fee (\$15 per record) should you request copies of your child(ren)'s records sent to yourself, another doctor or organization. If your child is age 18+ he/she will have to sign the request form. Upon request, a copy of your child(ren)'s immunization record will be provided to you at no charge. There is an additional \$10 charge for any physical exam form already completed.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. Should you have any questions about the above information PLEASE do not hesitate to call us at (847) 615-4654. We are here to help you. Failure to sign this form will result in immediate payment. We will not accept any deleted or crossed out information on this form.

Signature: _____

Date: _____

****I authorize LAKE SHORE PEDIATRICS to charge to the credit card number listed below any balance that is my responsibility. This will in no way effect my ability to dispute an insurance claim with the insurance company. I may reverse this decision in writing at any time.**

Name on card _____

CC# _____

Signature _____

Date _____

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