CASAS ADOBES PEDIATRICS

MEMBER OF ARIZONA COMMUNITY PHYSICANS

Financial Policy

Patient's name: _____ Date of Birth: _____

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INSURANCE: **At the time of service you are responsible for the co-pay, deductible and co-insurance amounts and any amounts not covered by the insurance company.** A claim will be submitted directly to the insurance company if all necessary information is provided, which includes a copy of the patient's insurance card and subscriber's information. If coverage is denied for any reason, you are responsible for the entire balance. It is your responsibility to contact the insurance company in the event of non-payment. Insurance benefits are a matter between you and the insurance company. You are ultimately responsible for the payment on your child's account. If the doctors are not contracted with your insurance company you are expected to pay for the child's visit at the time of service.

NO INSURANCE: If you do not have insurance or unable to provide insurance information, you are expected to pay for your child's visit at the time of service. There is a 20% discount.

PAYMENT FORMS: Cash, checks, Visa, Master Card, and Discover are accepted for payment. If the bank returns a check, there will be a $25.00 return check fee and you will no be able to use this form of payment.

DELINQUENT ACCOUNTS: If an account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collecting the balance. Balances over (60) days will be assessed a 1% per month finance charge. Balances sent to bad debt or a collection agency will be assessed a one time 30% finance charge.

If you have any questions regarding the financial policy, please ask prior to the appointment.

I have read and understand the financial policy and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my child's account with Casas Adobes Pediatrics and Arizona Community Physicians. I have provided to the best of my ability the information requested accurately and completely. **I understand I might be turned away for non-compliance of the financial policy.**

_____ _____

Responsible Party Signature Date

_____ _____

Responsible Party (Print) Relationship