



Decatur Pediatric Group, P.A.

FINANCIAL RESPONSIBILITY STATEMENT

Please read carefully!

Thank you for choosing Decatur Pediatric Group as your child's health care provider. We are committed to successfully managing your child's health. Please understand that payment of the bill is considered part of your treatment. This Financial Responsibility Statement must be read and signed by the child's guardian prior to any treatment. All patients should also complete our Patient Information and Insurance form before seeing the doctor. Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns.

While we do participate with many insurance plans, accounts covered by other plans must be paid in full at the time of service unless prior arrangements have been made. We accept Cash, Checks with prior approval and MasterCard, Visa, Discover or American Express.

Insurance:

Patients should understand that services are rendered and charged to the patient and NOT to the insurance company. As a courtesy we will attempt to bill your insurance. **If the information that you have provided is incorrect, you will be obligated to pay for ALL services rendered.**

We will be happy to file insurance claims for you provided we are participating provider in your plan. We cannot file any claims without a current copy of the insurance card. If your insurance company requires you to choose a PCP, Decatur Pediatric Group or Provider's name must be on the card. Please present your insurance card at each visit. This will help to insure that our records are current and that we have any pertinent information we may need to make the filing of your claims go smoothly.

You are responsible for knowing what your insurance company covers. Plans can differ, even within the same insurance company. Please be aware that some, and perhaps all of services provided may be non-covered services and not considered reasonable and customary under your insurance plan.

Other services that we provide which may not be covered by your plan include counseling for behavior or learning problems, including ADD, extended telephone conversations, and written correspondence. You will be billed for these services directly. Should your insurance carrier require you to use a specific lab or other outside facility, it is your responsibility to **inform the nurse**. Failure to do so may result in charges to you, which your insurance company does not cover.

The balance of any claim filed is your responsibility whether or not your insurance pays. ***In the event that your insurance company does not pay within 45 days, you will receive a bill from this office. You will be responsible for payment of this bill within 30 days of the date of the bill.***

Co-Payments: Insurance companies require a co-payment for ***each and every office visit regardless of the services being performed.*** All co-payments are due at check-in, prior to treatment.

Referrals: Please be aware that some plans require pre-authorization before seeing a specialist. If you see the specialist BEFORE receiving approval, you may be required to pay out of pocket. If you must take your child to the urgent care facility after hours or on weekends, please contact our referral department at extension **827** the next business day so we may do a referral for you.

Missed Appointments: All visits are by appointments only. Unless cancelled 24 hours prior to the appointment time, there is a **\$25.00** administrative fee for missed "SICK" appointments and **\$50.00** fee for missed "WELL EXAM" appointments. Please help us serve you better by keeping scheduled appointments.

I have read and understand the Financial Responsibility Statement. I agree to these conditions.

X _____ Date: _____
Signature of Responsible Party

Please list all children (with 1st and last names) and their birthdays:

_____ Date of Birth _____
_____ Date of Birth _____
_____ Date of Birth _____
_____ Date of Birth _____

Payments may be made online at our website www.decaturrediatrics.com