

# PATIENT COPY – PLEASE KEEP FOR YOUR RECORDS



Welcome to Pendleton Pediatrics! We are pleased that you have chosen our practice to be your child's primary care physicians!

The Physicians and staff are dedicated to making this a pleasant experience for both you and your family.

We would like to acquaint you with the following financial policies that our office has established;

If you do not have insurance, or have insurance, but a service provided is not a covered benefit, all fees are to be paid at the time of visit. We offer a cash discount for cash paying patients who pay at the time of service. If you do not pay at the time of service, there will be no discount and the full amount will be due. We will be happy to provide a fee schedule at your request.

If you have insurance, your co-pay is due at the time of service. We also may ask you for any co-insurance or deductibles that may apply.

In the unfortunate event that an account becomes delinquent and goes to an outside collection agency, there will be a 30% collection charge that will be added to your bill. The undersigned jointly and severally agree to pay all costs.

If you have any questions regarding our billing policies or if you need to make financial arrangements with our office, please feel free to contact our billing department at (480) 385-5055, and speak to Vicki or Judy.

## INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

Thank you again for entrusting your family's health needs to our office!