



PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Patient name:

Date of birth:

Insurance Claims/Payment: As a courtesy, Reis Pediatrics will file your insurance claims for you; however, in the event that your insurance company denies payment for any reason or has not paid within 45 days, the parent(s) and/or guarantor will be responsible for any balance due. It is also the parent(s) and/or guarantor's responsibility to provide current insurance information, including the insurance subscriber number and mailing address, and to follow up on any benefit questions with the insurance carrier. **You are responsible for informing Reis Pediatrics of changes in insurance coverage within 30 days from the date of service, you may be responsible for any charges incurred due to delay in timely submission of charges.** We must emphasize that we are a medical care provider; our relationship is with the patient and not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Patient Account Charges and Statements: Co-Payment and/or any balance due on your account are requested at the time of your scheduled visit; we accept cash, check, and credit card. If you have no insurance plan at the time of your visit you will be required to pay 100% of the visit charges before being seen by our practice. You may contact our billing personnel to arrange and sign a monthly payment plan agreement if necessary. Reis Pediatrics may impose a collection fee and interest charge of 1.5% per month on any unpaid balance. In addition, a billing charge of \$5.00 may be charged for each statement a patient receives after the initial one.

Collections: If your account is over 90 days old with no payment activity, your account will be transferred to a collection agency. A \$35.00 fee will be added to your account upon transfer. If applicable, the parent(s) or guarantor is responsible for all related expenses incurred in the collection of the delinquent amount due. These may include, but are not limited to attorney's fees and/or other costs that Reis Pediatrics considers necessary in order to collect the delinquent amount due. To avoid collections, please be sure to pay your co-pay/balance at the time of your visit or mail in your payments by the due date shown on your statement.

Returned Checks: All returned checks are subject to a \$25.00 NSF fee and any bank fees incurred. In addition to the returned check, and the NSF fee & bank fees, you will also be required to pay any outstanding balance by your next scheduled visit. As a result, you may be placed on a cash/credit card only payment method for future appointments.

No Show and Cancellation Charges: As a courtesy to our physicians, staff, and other patients, we ask that you cancel your appointments at least 24 hours in advance. There is a \$35.00 fee for not showing up for or cancelling your well visits/physicals with less than 24 hours notice. If missing regular sick or follow up visits becomes a habit, you may be charged the \$35.00 fee as well. True emergencies will be handled accordingly between the parent(s)/guarantor and the office manager.

Credit Card Payment Authorization: (OPTIONAL): We request that your credit card information be on file with us to process any outstanding balances on your account. Our billing specialist will notify you before any transaction and will mail a receipt to your billing address.

Visa Mastercard

Name on Credit Card	Card Number	Exp. Date	Security Code
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Billing Address

By signing below, you are agreeing to and understand the above financial agreement and that you understand, as the parent and/or guarantor of the minor child described above as being the patient, that you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

Print Name	Signature	Date
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