BBSMD, PC
FINANCIAL GUIDELINES

THANK YOU FOR CHOOSING US AS YOUR PEDIATRICIAN! We are committed to your successful treatment. Please understand that payment of incurred fees is a part of your treatment. The following is a statement of our financial guidelines, which we ask you to read and sign prior to treatment.

- ✓ **All patients must complete our patient information form(s) before seeing the doctor.**
- ✓ **Full payment is due at the time of service if there is no insurance at the time of the visit.**
- ✓ **Co-pays and payment for non-covered services is due at the time of service.**
- ✓ **We accept cash, checks, VISA/MasterCard or Discover. A charge of $30.00 will be assessed for any returned checks.**

If you have any questions or concerns we are willing to help at any time. Our staff is here to serve and make your visit as pleasant as possible.

Regarding Insurance
We ask that all insurance patients have active insurance. Please notify us immediately if your insurance changes, so that we may make certain your claims are being filed to the correct company and in a timely manner. **It is the Members responsibility to verify we have the correct insurance on file.** Please remember that the financial obligation for medical treatment is between you and this office. Professional fees are due at the time service is rendered. This includes co-pays and any payment for non-covered services. The adult accompanying a minor and the parent-guardian are responsible for full payments.

Missed Appointments
In order to serve our patient's needs and to contain our costs, we ask our patients for a 2 hour notice on cancellation of appointments. Unless cancelled at least 2 hours in advance, our policy is to charge for missed appointments at the rate of $25.00. Please help us to better serve you by keeping scheduled appointments. The doctor works on a timed schedule so failure to appear for an appointment affects many patients. Your cooperation in this matter is greatly appreciated.

Please be aware that repeated missed appointments will lead to termination of services, and accessed no-show fees and these fees will be your responsibility.

Financial Responsibility
Please notify our Office Manager immediately if you need to make special financial arrangements for payment of your account. Accounts delinquent more than 90 days will be turned over to our attorney for collections. In the event of nonpayment of charges for services rendered, I agree to pay all costs of collection including a reasonable attorney's fee, court costs or collection costs and hereby waive all rights of exemption under the constitution of the state in which I reside. I understand the attorney's fee awarded by the court will be based upon all time spent on the case, until the debt is paid in full. I have read this contract and understand its provisions.

Thank you for understanding our Financial Guidelines. Please let us know if you have any questions or concerns.

_____
Patient(s) Name / Date of Birth

_____ _____
Signature of Parent/Guardian Date Signed