**Tadpole Pediatrics, LLC**

**FINANCIAL GUIDELINES**

Thank you for choosing us as your pediatric office. 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 provider.

\* Full payment is due at the time of services 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, please contact our office manager. Our staff is here to serve and make your visit a 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 to the correct company and in a timely manner. It is the MEMBER’S 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 payment.

**MISSED APPOINTMENTS:**

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 advanced, our policy is to charge for missed appointments at the rate of $25.00 and $50.00 for consult appointments. Please help us to better serve you by keeping scheduled appointments. The provider 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 incurred no-show 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 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