

**SKAGIT PEDIATRICS, LLP  
FINANCIAL POLICY**

Thank you for choosing Skagit Pediatrics as your child’s health care provider. We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our **Financial Policy** is important to our professional relationship. Patient care is not permitted without the written consent of the receipt and acknowledgment of the understanding of this policy.

**Patient Registration:** All patients must complete our “Patient Registration Form” before seeing the doctor or nurse practitioner. This must be updated yearly. \_\_\_\_\_ (initial)

**Payments:** FULL PAYMENT IS DUE AT TIME OF SERVICE. This includes applicable co-pays, co-insurance and payments for services not covered or denied by the insurance company. **IT IS YOUR RESPONSIBILITY TO PAY YOUR COPAY AT THE TIME OF EACH VISIT.** A \$10.00 service fee will be charged to your account, in addition to your co-pay, for each co-pay not paid at the time of service. Skagit Pediatrics, LLP accepts cash, personal check, debit cards, Visa, MC, and American Express. \_\_\_\_\_ (initial)

**Credit Card on File for Insurances with co-pays/co-insurance/deductibles:** Skagit Pediatrics, LLP requires keeping your credit/debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. You will be billed for any balance due on your account. You will have up to 30 days from the statement date to dispute the balance on your account or arrange payment. After 30 days if the balance has not been paid, your credit/debit card will automatically be charged. \_\_\_\_\_ (initial)

**Self-Pay Accounts:** If you do not have insurance, please come prepared to pay for your visit in full upon checkout. We offer a 10% discount for all self-pay services paid in full on the day of the service. \_\_\_\_\_ (initial)

**Missed Appointment/Late Cancellation/Late Reschedule Charges:** There will be a \$25.00 charge for all missed appointments and for appointments cancelled or rescheduled less than four (4) hours prior to the appointment time (Effective July 15, 2009). REPEATED FAILURE TO KEEP SCHEDULED APPOINTMENTS may result in dismissal of entire family from our clinic. \_\_\_\_\_ (initial)

**Children of Divorced/Separated Parents:** The parent who brings the child to the appointment must pay for service. It is not our responsibility to mediate payment disputes outlined in your divorce decree. \_\_\_\_\_ (initial)

**Payment Plans:** Payment plans are approved on a case-by-case basis and may be discussed with our billing team. Failure to make scheduled payments on the payment plan, or not paying off a balance in full, may result in your account being turned over to a collection agency and your family being dismissed from the practice. \_\_\_\_\_ (initial)

**DELINQUENT ACCOUNTS:** Accounts exceeding 30 days are considered past due. All accounts delinquent of payment after 90 days will be referred to an outside COLLECTION AGENCY. Any account referred to collection or file for bankruptcy may result in dismissal of entire family from our clinic. \_\_\_\_\_ (initial)

**RETURNED CHECKS:** A \$25 fee will be charged for any checks returned for insufficient funds. \_\_\_\_\_ (initial)

**INSURANCE:** Skagit Pediatrics, LLP is contracted with many PPO and HMO plans. Please contact your insurance company to verify we are listed as a contracted provider before scheduling an appointment. We bill your insurance as a courtesy. Complete and accurate insurance information must be provided at time of service. PLEASE BRING A COPY OF YOUR INSURANCE CARD(S) TO EVERY VISIT. Insurance is a contract BETWEEN YOU AND YOUR INSURANCE COMPANY, and YOU are responsible for payment as well as settling any insurance disputes. If we are contracted with your insurance, we will handle your claims according to our contract. We do not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information. If we are NOT contracted with your insurance company, we will bill your insurance one time only as a courtesy. If your non-contracted insurance has not paid the FULL BALANCE within 60 days, you will be expected to pay any balance due. **YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT.** \_\_\_\_\_ (initial)

**I HAVE READ AND FULLY UNDERSTAND THE SKAGIT PEDIATRICS, LLP FINANCIAL POLICY.**

\_\_\_\_\_  
Signature, Responsible Party

\_\_\_\_\_  
Patient name/DOB

\_\_\_\_\_  
Please Print Full Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient