Porter Pediatrics Comprehensive Pediatrics Health Care.PC
Billing and Credit Policy

Parents Name:_____(Please Print)

As with any professional office, our goal is to serve our patients efficiently and effectively. In order to achieve these goals, we request that each patient do their part by cooperating with the policies of our practice regarding insurance and payment.

FULL PAYMENT FOR ALL SERVICES IS EXPECTED AT THE TIME OF YOUR APPOINTMENT.

It is the patient's responsibility to:

- **Know their insurance plan benefits pertaining to pediatric well and sick visits. You will also be responsible for any payment for any services requested and/or approved by you, but not covered by your insurance carrier(it is the responsibility of the patient(parents/guardians) to know what is covered by your insurance carrier)If we do not participate with your insurance carrier full payment is expected.**
- **Notify their insurance company of the birth of any newborn**
- **Choose a primary care physician where applicable**
- **Carry your insurance card and present it to the receptionist at the time of service**
- **Make full payment of office visit co-payment, deductible, co-insurance, and non-covered insurance expenses at the time of your office visit**
- **Advise the staff of any changes in address, home or emergency telephone numbers and insurance coverage**

If your children are covered by two insurance plans, you are contractually obligated to fulfill all financial obligations set forth in your primary insurance policy. In the event that you do not have insurance coverage, please inquire as to our set fees when scheduling your appointment.

ALL PAYMENTS ARE REQUIRED TO BE MADE AT THE TIME OF SERVICE IN THE FORM OF CASH, PERSONAL OR BANK CHECK OR MONEY ORDER OR VISA.

In the event the bank returns a check to us, a service charge of $25(maximum) in addition to any bank fee will be added to the account. Keep all appointment, or if one is broken or cancelled with less than 24 hours notice, you may be subject to a $50 no-show fee.

I have read and understand the terms and conditions set forth above and agree to the terms and conditions therein. I further understand that failure to comply with this and any other policies of Porter Pediatrics, PC may result in Termination of professional services

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Parent/Guardian Date