DESERT PEDIATRICS

CASH PAY CONTRACT

PATIENT NAME:_____

PARENT/GUARDIAN NAME:_____

Initial all to acknowledge understanding:

_____ I do not have insurance coverage of **any kind** for my child, not private or Medicaid.

_____ I will be given a 40% discount off the usual charges and agree to pay for the entire visit at the time of service. I will not be billed.

_____ Because my child has no insurance coverage, I am eligible for immunizations provided By the Vaccine for Children Program. The vaccine is free. I am responsible for the Administration fee.

_____ If it is later determined that there was medical coverage in place for this child at the time of service, the insurance will be billed and I will be responsible for any patient responsibility determined by the insurance carrier. If there is a refund due, Medicaid patient's will be refunded when eligibility has been proven. Private insurance patients will be refunded when the insurance has paid the claim.

Returned checks: a $30.00 fee will be charged for the checks initially returned unpaid by your bank.

No Show Policy: Please notify us at least 2 hours prior to your appointment time if you are unable to keep the appointment. Failure to do so may result in discharge from the Practice.

I have read, understand and initialed Desert Pediatric's Cash Pay Contract.

PARENT/GUARDIAN SIGNATURE:_____

DATE:_____

DESERT PEDIATRICS

FINANCIAL POLICY

We are committed to providing your child with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans.

It is your responsibility to:

- **Bring your insurance card and photo I.D. to the first visit.**
- **Pay your Co-Payment and / or any deductibles at each visit.** Payment can be made by cash, check, or credit card. We accept VISA and MasterCard. We do not bill for Co-Payments.
- **Pay in full for any medical care or services that are not covered by your insurance plan.**

2. If your child does not have insurance, payment in full is expected at the time of service. Your child will be a "Cash Pay" patient in our office. We offer a discount to "Cash Pay" patients, and charges must paid at the time of service. See Cash Pay Contract.
3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP (primary Care Provider). You will need to choose a provider from our practice. If your insurance card lists another physician's name we will assist you in attempting to change the PCP prior to your appointment, but ultimately, it is your responsibility to make the necessary change in order to avoid being responsible for the entire visit.
4. **You are financially responsible for any amount not covered by your child's plan.**
5. **You are financially responsible for all charges incurred in your child's care and treatment.**
6. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.
7. If you fail to make payment in full for services that are rendered to you in a timely manner, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Accounts sent to collections will lead to dismissal from the practice for the entire family.
8. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Patient/Parent Information Form. We will scan your insurance card, ID, and Patient/Parent Information Form into your child's electronic medical chart. We will check these documents prior to releasing your child's records.
9. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

RETURNED CHECKS: A $30.00 fee will be charged for the checks initially returned unpaid by your bank. An additional $25.00 will be charged if the same check is returned unpaid a second time.

Patient Name:_____

Printed Name Guarantor/Guardian:_____

Signature:_____ Date:_____