FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

The primary goal of our practice is to provide the finest pediatric care to the children and young adults in our community. Since our practice has obligations that must be met, we ask that you agree to abide by our payment policies. Insurance coverage is an agreement between a patient and his/her insurance company for the payment of medical services. While we will attempt to assist you in obtaining payment from your insurance company, it is your responsibility to understand your coverage and to know your carrier's guidelines for obtaining medical services. You are ultimately responsible for full payment of charges incurred at the visit if your insurance carrier doesn't pay for any reason. For your convenience we accept cash, check, VISA and MasterCard.

- **Insurance Cards:** Please come to each appointment with all the necessary forms and current insurance cards so that we may have the most updated information necessary to bill the insurance company in a timely and accurate manner.
- **Name Changes:** In the case of a legal name change, proof of name change must be submitted to us so that the information we have matches the information your insurance carrier has. Please verify with your insurance carrier that they have the same patient name you provide us. Until proof of name change is provided, payment for visit is expected.
- **Legal Guardianship:** Proof of legal guardianship must be submitted before treatment is provided to patients.
- **Co-pays:** If your insurance company requires a co-payment, payment of the co-pay is due at the time of service. If you fail to make a co-payment at the time of the appointment, a $10 billing fee will be added to your account.
- **Non-insured Patients:** If you do not have insurance, payment is due at the time of service. We will give a 25% discount on the exam charge when payment is made in full at time of service. Established patients in good financial standing with the clinic have the option of paying a $100 deposit rather than paying in full, but there will be no discount available unless account is paid in full at time of service.
- **No Proof of Insurance:** See policy for non-insured patients above. The same policy will apply until proof of insurance is provided.
- **Non-Sufficient Funds:** Non-sufficient funds: When checks are returned to WFPG for non-sufficient funds, a $35 charge will be added to your account, and you will be asked to pay with cash or credit card for future visits.
- **Non-covered Services:** OHP/Commercial insurance patients will be required to make payment in full at time of service for services not covered by insurance.
- **Collections:** In the unfortunate event that we need to assign an account to a collection agency, we will add a fee of $150 to the delinquent balance on the account.
- **Missed Appointments:** Willamette Falls Pediatric Group has a policy of charging $50 for missed appointments. We may also choose to discharge a patient from care for repeated incidents of missed appointments. Please call 24 hours in advance to cancel or reschedule appointments.

As responsible patient or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of Willamette Falls Pediatric Group as stated above.

Signature of Guarantor: _____ Date: _____