**BOONSLICK PEDIATRICS, L.L.C.**

**FINANCIAL POLICY**

Thank you for choosing Boonslick Pediatrics as the health care provider for your child. We are committed to providing the best quality care to each of our patients. The following is a statement of our Financial Policy to help you understand your obligations, which we require you to read and sign.

**Regarding Insurance**

All charges will be submitted to your insurance plan provided that we are a participating contract provider for that plan. Please understand that the agreement of the Insurance Company is a contract between you and your insurance company. We are required, per this agreement, to collect co-payments and balances due at the time of service. Co-pays, coinsurance and deductible amounts are your responsibility. Should we need to send out a statement to collect co-pays, a $5 service charge could be added for each statement sent each month. Please bring your insurance card to each visit.

**Separation/Divorce Policy**

The parent accompanying the child is responsible for paying the copay or any charges pre-determined to not be covered by the insurance at the time of service. It is your responsibility to keep our office informed of any address, phone number, or insurance changes, as we can only work with the information provided to us. The parent deemed, "responsible/guarantor" will be financially responsible for any account balance unless court ordered otherwise. Please keep the Office Manager made aware of special billing circumstances.

**Copays**

Copays are a part of your contract between you and the insurance company and by law are due at the time of service. Insurance companies do perform audits and a breach of contract could warrant your loss in coverage. Any copay not paid at the time of service will include a $5 service charge for each month billed out to the patient.

**Minor Patients**

The adult accompanying a minor patient (parent, guardian, step-parent, other family member or care-giver) will be responsible for payment of copay or any pre-determined charges not covered by the insurance at the time of service. In the event of a true medical emergency, other arrangements may be made with the Office Manager.

**Adolescent Unaccompanied Patients**

Adolescent patients not accompanied by a parent are responsible for payment of the copay or any charges pre-determined not covered by the insurance at the time of service.

**Billing Fees**

A $5 billing charge could be added to any unpaid balances after two unsuccessful attempts have been made. A $35 service fee will be charged to your account for any returned checks.

**Account Balances**

All coinsurance and deductible amounts are due 30 days after receipt of Statement of Account from Boonslick Pediatrics. Statements are sent monthly to the responsible party provided. We may also try and collect by telephone, mail or email correspondence. If balances are neglected to be paid, and after many attempts, your account will be turned over for collections with inclusion of a service charge at 30% over the account balance. Balance must be paid in full at the time of service unless previous billing arrangements have been established with our office. We accept cash, check, money order, or credit/debit card (Mastercard, Visa, Discover, and American Express).

By signing this agreement, you are stating that you have read the Financial Policy, understand, and agree with the terms. If you have any questions or concerns, please contact the Office Manager at 636-441-4144, Monday through Friday 8:30am-4:30pm.

*I, the parent of ________________________________, have read the Financial Policy and I understand and agree to these terms and to assignment of benefits from my insurance company to Boonslick Pediatrics, L.L.C.*

| Signature of Responsible Party | Printed Name | Date |
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