FINANCIAL POLICY

Thank you for choosing Neighborhood Pediatrics as you healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our office is available to discuss our fees and billing policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, and MasterCard. As a courtesy to you, it is the policy of Neighborhood Pediatrics to bill your insurance carrier, *although you are ultimately responsible for the entire bill.* As the responsible party, please understand;

(PLEASE INITIAL THE FOLLOWING)

____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

____2. Fees for service, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

____3. *All charges are your responsibility whether your insurance company pays or does not pay.* If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Neighborhood Pediatrics, you recognize an obligation to promptly remit payment to Neighborhood Pediatrics.

____4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Neighborhood Pediatrics, I will be responsible for all costs of collecting monies owed and collection agency fees.

____5. The above does not apply for those patients that are considered Worker's Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claims is controverted.

At Neighborhood Pediatrics, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing, if you have any questions please call (978) 342-4437.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____ DOB_____

Signature of Patient or Responsible Party: _____

Date: _____