

GENESIS PEDIATRICS, LLC
BILLING AND CREDIT POLICY (1/1/10)

Parents Name: _____ (Please print)

It is one of Genesis Pediatrics' goals to offer quality service at a reasonable cost. We strive to concentrate on serving our patients and to spend as little time as possible on administrative duties. To achieve this goal we need your cooperation.

Full payment for all services not covered by your insurance (including co-payments) is expected at the time of your appointment unless other arrangements are made. **NOTE: Co-payments not made on the date of service will incur a \$10 service charge.** Deductibles and co-insurance payments are expected upon receipt of the first billing statement from Genesis Pediatrics. You will also be responsible for any payment for any services requested and/or approved by you, but not covered by your insurance carrier. In addition, you will be responsible for any services rendered to your child(ren) for services requiring interpretation by an outside agency and billed by them directly (ie. Labs, etc). (It is the responsibility of the patient (parents/guardians) to know what is covered and not covered by their insurance carrier.) If we do not participate with your insurance, full payment is expected on the date of service. We will provide sufficient documentation for you to submit a claim to your insurance company for your visit, and reimbursement should be sent directly from them to you. For your convenience, payments to Genesis Pediatrics can be made by cash, check or credit card and can be paid in person, by mail or telephone.

By signing below, I/We have selected Genesis Pediatrics as my/our child's pediatric primary care provider and agree to:

- **Bring my child myself or send him/her in with someone whom I've listed on the Family Data Sheet.**
- **Make full payment or co-payment at the time of service as detailed above.**
- **Keep all appointments, or if one is broken or cancelled with less than 24 hours notice, I/We may be subject to a \$30 missed appointment fee.**
- **Remain in contact with Genesis Pediatrics billing staff regarding any payment arrangements different than full payment on date of service.**
- **Keep the account current through timely payments and communications required.**
- **All accounts not current are subject to the Genesis Pediatrics collection program and could result in a loss of privileges/relationship with Genesis Pediatrics.**
- **Grant the right to collect all reasonable costs, billing fees, attorney's fees, collection agency fees and disbursements associated with any legal action taken to recover a debt for services rendered.**

A billing charge is automatically added each month to outstanding accounts unless prior arrangements are made. **Remember** it is the policy of Genesis Pediatrics, that **both** a father **and** mother are responsible for a minor child's care and bills regardless of any other financial/legal arrangements dictating who will pay.

In the event the bank returns a check to us, a service charge of \$30 (maximum) in addition to any bank fee will be added to the account.

Financial hardship should never stand in the way of medical care. Since open communication can benefit both parties, any hardship should be discussed with Genesis Pediatrics earlier rather than later. This will simplify a difficult situation. Please feel free to speak with the Billing and Accounts Department if you have any questions about our policy.

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 GENESIS PEDIATRICS, LLC MAY RESULT IN TERMINATION OF PROFESSIONAL SERVICES. (A DUPLICATE COPY OF THE BILLING AND CREDIT POLICY IS AVAILABLE FOR MY REFERENCE, UPON REQUEST).

Father / Mother / Legal Guardian (Please Circle one)

Date

Father / Mother / Legal Guardian (Please Circle one)

Date