WESTSIDE PEDIATRIC CLINIC, P.C.

CREDIT POLICY

Parents are responsible for any balance not covered by their insurance company. If a patient is uninsured, payment is due at the time of service. If an insurance claim is denied, payment is due within 30 days of the denial. Should you need to make payment arrangements, you must do so with our Billing Department within 30 days of the denial. If you are not sure of your covered benefits i.e., Well Child Visits, it is your responsibility to contact your insurance company or employer benefit office.

As a courtesy to you, we will bill both your primary and secondary insurance companies, provided we are given current and complete information at the time of service. Many insurance carriers require a co-payment at the time of service. We are contractually required to collect the co-payment. If you cannot pay your co-payment at the time of service, a 10.00 billing fee will be applied to your account for non-payment. We make no exceptions to this policy. Also, please be aware that your child/ren can be discharged from our practice for an ongoing history of missed co-payments.

If your check is returned to us for insufficient funds, a 25.00 fee is applied to your account. If it is returned a second or third time, a 10.00 fee is applied for each attempt. Should your account become delinquent, we will send your account to Transworld Systems, Inc. and there is a 25.00 fee associated with this process. Please be aware that you will be responsible for all collection agency and/or legal fees incurred.

We understand the difficulties involved in divorce and court orders. However, Westside Pediatric Clinic, P.C. does not participate in the disputes between divorced parents. We will look to the custodial parent for reimbursement of any amounts owed to our clinic. If you have a court order, you may forward the statement to the appropriate party. However, the custodial parent is ultimately responsible for any balance owed.

I have read and received a copy of the Credit Policy of Westside Pediatric Clinic, P.C. I accept this policy for treatment of my child with Westside Pediatric Clinic, P.C.

____

Patient's First Name Last Name

____

Signature Date