Statement of Financial Policy

Insurance:
Complete and accurate insurance information must be provided to us at the time of service. If you do not have insurance, payment for services is expected at the time of service. All Co-pays are due at the time of service. Aspen Park Pediatrics, PC cannot waive or change co-pays.

Please be familiar with your insurance policy so you are aware of what services are covered. You may be responsible for payment of medical services provided, if your insurance company denies payment.

Personal Information:
Please inform us of any changes in your address, home phone number, business phone number or mobile phone number. We will update your information at every visit.

Payment:
We accept cash, check, Visa and MasterCard. There will be a $20.00 charge on all returned checks. Payment on your portion of bills is expected within 30 days. There will be a $10.00 billing charge accessed for every 30 days the account is past due. There will also be a $10.00 charge for co-pays not paid at time of service.

Cancellations:
If you need to cancel/change your appointment, please call 24 hours prior to your appointment. No-shows or cancellations made with less than 24 hours notice will be subject to a charge of $25.00 for a sick visit and $50.00 for a well visit.

Nonpayment:
If this account is sent to collections, the undersigned Responsible Party agrees to pay all costs of collection.

I authorize my insurance benefits to be paid directly to Aspen Park Pediatrics, PC.

I fully understand and agree to all terms set forth in the above statement.

____
_Print Parent/Legal Guardian Name **Child's Name**

____
_Child's Name **Child's Name** **Child's Name**

____
_ Sign Parent/Legal Guardian **Name** **Date**

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