PEDIATRICS WEST, PC FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable deductibles, coinsurance and copayments for participating insurance companies. **PEDIATRICS WEST, PC** accepts cash, personal checks (in-state only), VISA, MasterCard, Discover and American Express. Return checks are sent to BC Services Collection Agency.

Accounts with an outstanding balance 60 days or more must make arrangements for payment prior to scheduling appointments.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, coinsurance and/or copayments at the time of service. If you need assistance or have questions, please contact the **Billing Office between 8:30 a.m. and 4:00 p.m., Monday through Friday at 720-284-3717.**

REFUNDS:

Patient/guarantor credits in amounts less than $30.00 will be retained on account to be credited toward future balances unless a written request for refund is received.

REFERRALS

Your children's care is best handled by a partnership between you and your physician. Receiving a referral for a specialist from our office guarantees this. If a referral is necessary we will obtain one for you. Retroactive referrals are not guaranteed. Payment for services provided by specialists are determined by your insurance company.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **PEDIATRICS WEST, PC** Financial Policy. I agree to assign insurance benefits to **PEDIATRICS WEST, PC** whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured/authorized representative: _____

Child's Name: _____Birthday: _____

Child's Name: _____Birthday: _____

Child's Name: _____Birthday: _____

Child's Name: _____Birthday: _____

Child's Name: _____Birthday: _____

Today's Date: _____