# PAYMENT EXPECTATIONS POLICY
# PEDIATRIC & ADOLESCENT CENTER, SC

Thank you for choosing Pediatric & Adolescent Center, SC for your pediatric care.

As a courtesy to our patients, we accept most insurance plans and submit these claims on your behalf. To do this efficiently, it is very important that we have accurate and complete information on your insurance coverage. In addition, it is important that all your insurance plan's requirements are met PRIOR TO receiving services. This may include your payment of copays, deductibles, and non-covered services at the time of service. Payment of copays, deductibles, and non-covered services are expected at the time of service. Patients without insurance are expected to make payment or other arrangements prior to services.

Pediatric & Adolescent Center, SC accepts the following payments:

1. Cash, personal check, money order, Visa and Mastercard
   (There is a $20 returned check fee)

2. Budget plans: Arrangements should be made with the billing service for Pediatric & Adolescent Center. Initially, a deposit of 25-50% of the total bill is to be made, followed by 25% of the remaining balance per month until the remaining bill is paid in full.

It is the patient's/guardian's responsibility to pay for all services provided not covered by insurance. That includes amounts denied or not covered by your insurance plan. If, once submitted, we have not received payment from your insurance plan by 30 days after the date of service, or if the insurance has denied payment in full or part, we will bill you for the balance. We will bill outstanding balances to you monthly, and payment is due upon receipt.

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I hereby authorize Pediatric & Adolescent Center, SC and its agents to submit health insurance claims for any service and receive payment from my insurance carrier.

I authorize Pediatric & Adolescent Center, SC and its agents to release information from my or my child's medical chart that pertains to filing and providing adequate documentation for any insurance claim. I am aware that if I refuse to consent to the release of information, or if Pediatric & Adolescent Center, SC does not have adequate information on file for me, the charges incurred will be my responsibility.

I hereby state that I have fully disclosed all insurance coverage and the information is true. I understand and agree that I am responsible for payment of all services received from Pediatric & Adolescent Center, SC not covered by my insurance plan. I understand that consent has no expiration date and is revocable up until the time that billing action has been undertaken.

Patient name: _____

Print name of Guarantor: _____

Signature of guarantor: _____ Date: _____