FINANCIAL OBLIGATION POLICIES

In compliance with the Federal Consumer Protection Act, Shoreview Pediatrics wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to a member of your household/family.

1. Subscriber consents to covering all costs associated with out-of-network services including, but not limited to laboratory, imaging, specialists, emergency room, urgent care and therapy. Shoreview Pediatrics is not financially responsible.

2. All co-payments must be made at the time of service.

3. There will be a $50.00 no show fee for all well exam appointments that are cancelled or "no-showed" with out a 24 hour notice.

4. Notification of changes to your account including insurance company, phone numbers, and address MUST be given at the time of service or prior to your appointment.

5. We will furnish you with a monthly statement of your account

6. If you are unable to pay your balance within 30 days of receipt of your statement call our office to arrange a payment program.

7. We deem the financially responsible party as the parent or guardian bringing the child to our office requesting service. This party is responsible for insurance filing and insurance payment arrangements.

8. We do file all visits electronically to your current insurance plan.

9. We reserve the right to bill for telephone calls and electronic communication between parent/patient and Shoreview Pediatrics staff.

10. We reserve the right to bill for an additional sick visit concurrent to the wellness visit if issues outside the wellness care are discussed.

Payment of Services rendered:

1. You will be responsible for unpaid balances on your family's account.
2. Cash, checks, Master Card, Visa, Apple Pay, are options for payment.
3. Extended payment programs are available to you if arranged and approved by our business office.

The undersigned hereby acknowledges to have read and agrees to the above FINANCIAL OBLIGATION POLICIES of Shoreview Pediatrics, S.C.

Date: _____ **Signed:** _____

Printed Name: _____ **Patients Name:** _____