Pediatric Associates of Hampden County

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

Payment is required at the time of service. We accept cash, check, or credit card (Visa, Discover, American Express and MasterCard).

Co-payments are required at the time of service. The amount of co-payment varies with different plans. You are responsible for knowing the co-payment amount and primary care physician listed for your child.

All charges not covered by your insurance company are your responsibility.

Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

By signing below I understand and agree to the above Financial Policy.

_____ _____

Patient's Name Patient's Date of Birth

_____ _____

Parent/Legal Guardian's Name (if applicable) Relationship to Patient

_____ _____

Signature of Parent/Legal Guardian/Self (if 18+) Date