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Patient Financial Responsibility Agreement

Thank you for allowing Cepero Pediatrics to be a part of your child's medical care. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your child's medical care as stress-free as possible.

For patients without insurance benefits, payment is due in full at the time of service.

Insurance Claims/Payment: As a courtesy to you, we will bill your insurance. You must provide us with a copy of your valid insurance card. If your insurance coverage changes, you must provide new insurance information as soon as possible. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. Co-payments and deductibles must be paid at the time of service. Our office can only **ESTIMATE** the approximate percentage or amount that your insurance may pay. Some or perhaps all of the services rendered may not be covered under your insurance plan. In this instance, as the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

Newborn Medicaid Patients should produce proof of Medicaid coverage as soon as possible. If the child reaches 1 month of age and no proof is provided, and we are unable to verify coverage, the parent/legal guardian will be responsible for the entire bill.

No Show and Cancellation Policies: As a courtesy to our physician, staff and other patients, we ask that you cancel your child's appointments at least 24 hours in advance. There is a $25 fee for not showing up or canceling his/her appointment with less than 24 hours' notice (does not apply to Medicaid patients). This fee must be paid within 2 weeks of being notified. True emergencies may be given special consideration. If you cancel your child's appointment with less than 2 hours' notice, it will count as a no show. All patients who accumulate 3 no-show appointments risk being discharged from the practice. If you are more than 15 minutes late for your appointment, it will be counted as a no-show and will need to be rescheduled.

Non-Payment: If your account is 30 days past due a late fee will be assessed. If your account is more than 90 days past due, you will be advised that you have 30 days to pay your account balance in full. If your balance remains unpaid, you may be notified that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only be able to treat you on an emergent basis, and your account will be turned over to a collection agency.

Returned Check Policy: If payment is made by check, and the check is returned as Non-Sufficient Funds (NSF), or Account Closed (AC), the patient's Responsible Party will be responsible for the original check amount in addition to a $35 fee. Once notified by our office, if payment is not made within 30 days, the account may be turned over to a collection agency and risk being discharged from our practice.

For your convenience, we accept all major credit cards, debit cards, cash and checks.

By signing below, you are agreeing to and understand the above financial agreement and you acknowledge that as the parent/legal guardian you are responsible for any charges incurred and agree to pay then as stated above.

Patient Name (Please Print) _____

Responsible Party Name (Please Print)_____

Responsible Party Signature_____ Date_____