





# northsuburban

## PEDIATRICS

### Financial Policy

North Suburban Pediatrics is contracted with many different insurance plans. It is the insured's responsibility to check with their insurance plan for policy provisions and to see if their doctor is contracted with the plan. Please be advised that all services are billed according to the medical care that was provided, not to what is covered by your insurance plan. The office will bill your insurance as a courtesy to you, however, any claims not paid after 60 days become your responsibility to dispute with your insurance company.

#### **ALL COPAYS ARE DUE AT TIME OF SERVICE.**

In accordance with our signed contracts with the insurance carriers, we are responsible for collecting these copays; they cannot be billed to you, co-pays will be added to well physicals if significant health problems or chronic conditions are addressed during the visit. All balances after insurance pays are due within 30 days of receiving your statement. All financial questions or disputes are to be referred to the Billing Department

Starting January 1<sup>st</sup>, 2018 a \$25 fee will be charged for all missed appointments that are not cancelled by 10am on the day of the appointment.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



**North Suburban Pediatrics, S.C.**

**Family Account #** \_\_\_\_\_

**Sunday and Holiday**

I understand that there is a \$35.00 fee for Sunday and Holidays that must be paid at the time of service along with our original co-pay.

\_\_\_\_\_  
Authorizing Signature

\_\_\_\_\_  
Relationship

**Assignment of Insurance Benefits/Payment Guarantee/Collection Fee**

I hereby authorize payment to be made directly to North Suburban Pediatrics for Insurance benefits payable to me. I understand that I am financially responsible to North Suburban Pediatrics for any covered or non-covered, as defined by my Insurer, which are not paid by my primary Insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorney'

\_\_\_\_\_  
Signature of Policy Holder

\_\_\_\_\_  
Date



**northsuburban**  
PEDIATRICS

**HIPAA Notice of Privacy Practices**

**Acknowledgement**

**I have received a copy of North Suburban Pediatrics, S.C's HIPPA Notice of private practices.**

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Patient Signature

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Date