BLOOM PEDIATRICS

FINANCIAL POLICY

We would like to thank you for choosing our therapy group for your family. We are committed to providing you with quality services. It is important to our professional relationship to have a clear understanding of our financial policy. If you have special circumstances, we are here to work with you. We accept cash, check or most major credit cards for applicable payments. For any returned checks, a $25.00 NSF fund fee will be charged. Please read and initial each section, and sign this agreement. Let us know if you have any questions prior to signing. **initials**_____

INSURANCE

As a courtesy to our patients, we will submit your claims to select insurance companies. Your insurance policy is a contract between you and your insurance company and this practice is not a part of that contract. It is your responsibility to determine what benefits are covered by your insurance plan, including any exclusions, limitations, or required documents (like a prescription). Your individual benefits may change annually. If your insurance company has not paid your claim in 45 days, the balance will be transferred to you and becomes your responsibility. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. Please bring your insurance card to each visit and be prepared to pay any co-pays, deductibles or fees applicable. **initials**_____

SELF PAY

We expect payment at time of service unless prior arrangements have been made. If you are unable to pay for services, it is your responsibility to inform us prior to your visit. **initials**_____

PAYMENT PLANS

A payment plan may be available based on need. All payment plans are required to be paid in full within a six month time period. **initials**_____

COLLECTIONS

In the event of non-payment of a bill, this practice shall be entitled to the right of recovery for all collection expenses, including court costs and reasonable attorney fees incurred for the purpose of obtaining payment of the amount due. If your account goes to a collection agency, you may be dismissed as a patient from our practice.
initials_____

Please sign that you have read, understand, and agree to this Financial Policy.

_____ _____
Patient's Name (Printed) Date of Birth

_____ _____ _____

Patient's Signature or Representative Relationship Date