Patient Responsibility Agreement

SUBURBAN PEDIATRICS
Phone: (716) 565-9030 | Fax: (716) 565-9038
www.suburbanpediatrics.com

PATIENT NAME: _____

DATE OF BIRTH: _____

We request that you assist us with the following:

1. **Demographic Information**. It is your responsibility to provide accurate and up-to-date personal information to our office no less than annually, and also when any changes occur. Required demographic information includes a reliable residential address (not a P.O. Box) for the patient as well as reliable residential information for both parents if not residing at the same address; current telephone numbers for both parents; an emergency contact and telephone number of someone not residing with you; and a current reliable email address. An individualized form for each child is required.
2. **Insurance Information**. It is your responsibility to provide accurate and up-to-date medical insurance information and to notify us immediately of any changes in your insurance coverage. Please note that you are personally responsible for all charges incurred. To the extent that you fail to provide timely or accurate insurance information that results in non-payment for services, or your insurance denies coverage, you will be invoiced directly and payments are expected within 30 days.
3. **Payments**. You are responsible for, and expected to promptly pay all copayments, coinsurance payments, or unpaid deductibles at the time service is provided. The person bringing the patient in is responsible for payment. Failure to pay at the time service is provided will result in a billing fee of $15 to cover the cost of a statement being sent to you.
4. **Appointments**. We ask that you cancel any appointment you must change with at least 24 hour notification to our office. No-show appointments are very costly to everyone – we staff based on schedule needs and we can't see other patients who may need or want a visit at that time. Therefore, we have implemented a $50 charge for any visit not canceled with enough notice to use that appointment slot. This means that for each patient that does not come as scheduled, a $50 fee will be charged.
5. **Medical Care**. Our medical providers want to provide the best possible care for your child. There may be times when the standard of care or the physician's medical judgment determines that your child needs a service or test that may not be covered by your insurance carrier. The office will make every effort to notify you when we are aware of possible coverage issues. Unfortunately, we are unable to know which insurance carriers may deny services usually covered OR services that the physician or medical provider feels are necessary for your child. You agree to be responsible for payment of any/all non-covered services rendered by Suburban Pediatrics' physicians or medical staff.
6. **Forms**. We will provide each patient with a Health Assessment Form (HAF) at the end of their annual well visit. This form is good for one year from the date of the exam and can be used for most school, sports and camp activities. Any additional forms, special forms or motor vehicle accident forms will be completed at a charge of $10 per form.

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7. **Past-Due Accounts**. It is your responsibility to keep your account current with Suburban Pediatrics. A billing fee of $15 will be added to all accounts that must be re-billed. In addition, should your account remain unpaid, it will be flagged for non-payment and you will not be able to schedule appointments until arrangements have been made to clear your outstanding balance. Any account that remains unpaid past 30 days will accrue interest at the rate of 8% per annum.
8. **Collections**. If you fail to make any payment when due, Suburban Pediatrics reserves the right to refer your account to a third party for collection. You will be responsible for all costs associated with collection, including reasonable attorneys' fees.

FINANCIAL/PATIENT RESPONSIBILITY. I have read the above and understand and accept the terms of patient responsibility. I understand that, in the case of non-payment, I will be responsible for any and all collection fees and or attorneys' fees.

_____ _____

Parent/Guardian Signature **Date**

_____

Printed Name of Parent/Guardian

_____ _____

Witness **Date**