Chesapeake Pediatrics & Adolescent Associates, P.A.

Parents are required to pay for their child's health care at the time services are provide. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard, Visa and Discover cards.

If is your responsibility to bring your most current insurance card with you to ***every*** office visit. You will be asked to present the card upon arrival along with any applicable co-payment. If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, your will be expected to pay at the time of service.

Billing and Nonpayment: Co-payment and deductible are payable in full at the time of service. If you do not have an active/valid insurance card, payment is expected at the time of service. Please check with your plan to verify that we are a participating provider. Any services received and later denied by your insurance carrier are your responsibility. This arrangement is part of your contract with your insurance company. If you balance is 90 days past due, we may refer your account to our collection agency, unless payment plan arrangements are made with our office.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you do not supply this information within a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next appointment so we can make the necessary changes to help you receive your maximum benefits.

Covered/Non-Covered Services: Chesapeake Pediatrics is not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover. The billing staff of Chesapeake Pediatrics will file all claims for covered services with your insurance company, if the physician is a contracted provider.

You are responsible for any balances that may be due to the physician as a result of:

- Co-insurance or co-payments
- annual deductible amounts
- non-covered services
- out-of-network charges
- terminated coverage
- exhausted benefits
- no insurance coverage
- failure to respond to insurance company correspondence or inquiries
- failure to list our physician as your Primary Care Physician

Release of Information and Payment Authorization:
All insurance Companies and Third Party Payers: I hereby authorize Chesapeake Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize my insurance carrier or its intermediaries to issue payment to Chesapeake Pediatrics and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.
Guarantee of Payment: I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Chesapeake Pediatrics to my child(ren) or the patient indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days.
Statement of Responsibility: The policy of this office is the parent or legal guardian who requests treatment for this child is responsible for all fees and services. Insurance co-payments are expected the day of service unless arrangements are made in advance. Any remaining balances after insurance payments are that of the financially responsible party. When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein including but not limited to reasonable attorney's fees may be sent to outside collection firms for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, reasonable collection agency fees, attorney's fees, and court costs. I Also understand and agree that if my personal check is returned for any reason, I will pay a $35.00 returned fee and my personal checks will no longer be accepted as payment for services rendered.

_____ _____
Patient Name Patient Date of Birth

X_____ _____
Signature of Patient or Parent/Guardian if Patient is under 18 year of age Date