WNY Pediatric ENDOCRINOLOGY

FINANCIAL POLICY

We are committed to providing you with the best care, and we are happy to discuss or professional fees with you at any time. Your clear understanding of our financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

1. Insurance cards must be presented at every visit. Insurance information will be verified by the receptionist.

2. Full payment is expected at the time of service unless other arrangements have been made. There will be a $10 charge for all copays not paid at the time of service.

3. High deductible health plan holders are expected to pay $150 (initial)/$75 (follow-up) at the time of service and the balance will be billed after it has been submitted to insurance.

4. If an appointment is broken or cancelled within 24 hours of the appointment, a charge of $50 may be applied to your account.

5. Returned checks are subject to a $25 service charge and may result in termination of your privilege to pay by check on future visits.

6. Past due patient balances may be referred to a collection agency for recovery. If this happens, you will be responsible for any collections fees.

Please check with your insurance company if you have any questions regarding your health care coverage and fees.

I hereby authorize payment of medical benefits billed from my insurance to **WNY Pediatric Endocrinology, PLLC.** I hereby accept responsibility for payment of any services provided to me that are not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance. I agree to all copayments, coinsurance, and deductibles.

_____ _____

Patient Name (please print) **Date of Birth**

_____ _____

Patient Signature (guardian if under age 18) **Today's Date**

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