Hillsborough Pediatrics Patient Agreement

Initial _____ INSURANCE PLANS: I understand it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen under “out of network” benefits.

Initial _____ COVERAGE: I acknowledge that Hillsborough Pediatrics is not responsible to know what services my insurance covers. I shall direct questions regarding health insurance policy coverage to my insurance company.

Initial _____ FINANCIAL COMMITMENT: I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan at the time of my visit. If I do not have a copay or have not come prepared to pay past due balances, my child’s appointment may be rescheduled for a later time. Furthermore, I understand that if someone other than me is bringing my child to Hillsborough Pediatrics, they will be responsible to pay for copays and any past due balance.

Initial _____ DEMOGRAPHIC VERIFICATION: I am aware that I will be asked to verify insurance and demographic information so records remain current.

Initial _____ VACCINE POLICY: Hillsborough Pediatrics’ providers adhere to the CDC & AAP vaccination schedule. The practice does not accept patients whose parents refuse to vaccinate their children.

Initial _____ NO INSURANCE AT THE TIME OF SERVICE: If insurance benefits cannot be determined, I understand that payment is required in full at the time of service. In some circumstances, I may have the option to put a credit card or debit card on hold until I’m able to provide proof of insurance.

Initial _____ CREDIT CARD ON FILE: I authorize Hillsborough Pediatrics to keep my credit card on file. I understand the card may be processed if my account with the practice is overdue.

Initial _____ PAYMENTS: I commit to promptly pay all amounts that have been determined by my health insurance to be patient responsibility upon receipt of my statement. If I have not paid my bill or have not arranged for a payment plan, I authorize Hillsborough Pediatrics to process my credit card on file.

Initial _____ SERVICE FEES: I understand my account will be charged $25 for NSF/Returned checks.

Initial _____ FORMS FEES: I understand Hillsborough Pediatrics charges for forms. If I need the form expedited (same day) there will be an additional RUSH FEE.

Initial _____ LATE ARRIVALS: I’ve been made aware that if I arrive more than 20 minutes past my scheduled appointment time (10 minutes for sick visits), the practice may have to reschedule my appointment.

Initial _____ NO SHOWS: I commit to give Hillsborough Pediatrics at least 24 hours’ notice if I am unable to keep my scheduled appointment. I understand Hillsborough Pediatrics will charge a $25 NO SHOW FEE. This fee is not covered by my insurance and will be my responsibility.

I have read, understood and agree to the above financial and office policy. I understand that Non-compliance with this policy may result in a dismissal from Hillsborough Pediatrics.

Patient Name _____ DOB: _____

Parent or Guardian's signature _____ Date: _____