PEDIATRIC ENDOCRINOLOGY ASSOCIATES

2650 Elm Ave. Suite 318 long Beach, CA 90806
(562) 595-0166 Fax (562) 595-6714

FINANCIAL POLICY

Thank you for choosing our Office. We are committed to the success of your treatment. Accurate information and prompt payment will allow us to continue giving you the best possible care.

A. If you DO NOT have insurance coverage, full payment is due at the time services are rendered.
B. If you have insurance coverage:
    1) You must provide current, accurate health insurance information at the time of service. Claims that are denied due to inaccurate insurance information will become the patient's responsibility.
    2) We will be glad to bill maximum of (2) insurance companies.
    3) It is your responsibility to know your insurance plan and to verify coverage for other doctors, recommended test and laboratory. We will bill your insurance company, however any co-payment, co-insurance and or deductible are due at the time of your visit. If insurance does not pay within 45 days, you will be responsible for the bill.
    4) A $10.00 service charge may be applied to patient account balances not paid within 30 days of receipt of our billing statement.
    5) If you fail to make payment in full or arrange for a payment plan with our office for the services that are rendered to you, your outstanding balance (over 60 days) will be subject to 18.5 % year interest and may be sent to a collection agency. A $50.00 collection charge will be applied to your account and you will be responsible for the fees assessed by the collection agency.

C. There will be a fee of $30.00 to complete any work, school DMV or other requested forms and a $30.00 fee to release medical records.
D. Our practice is committed to your health care, and we ask that you do the same. **Please give us a call 24 hours in advance if you are unable to keep your appointment, otherwise you will be subject to a no-show fee of $50.00.**
E. Regardless of your insurance coverage, you are ultimately responsible for full and timely payment of all charges incurred in our practice.

We accept cash, check, Visa, MasterCard, American Express, Discover and Bank Card. Please sign that you have read and agree to this Financial Policy.

X_____ Date Signed_____
Signature of Patient or Responsible Party
Print Name_____