Patient Financial Policy Agreement

Patient Name:	DOB:

Agreement to Pay All Charges for Services Rendered. In consideration for providing services, I agree to pay for all charges for services provided to me, to my minor children, or any minor child for whom I have authority to make medical decisions that are not covered by any benefit plan. I expressly guarantee payment of all charges for medical services rendered, or to be rendered, by Grow Pediatrics to me, my minor children, or any child for whom I have authority to make medical decisions.

Financial Policy Terms. I understand and agree to Grow Pediatrics' financial policy terms. Current policy terms are listed below. However, Grow Pediatrics reserves the right to amend the terms of this policy at any time and I understand that any policy changes will only be made on Grow Pediatrics' website and I waive any right to receive notice of those changes by any other method. I understand this authorization will remain in effect until I revoke it in writing.

- All amounts are due on receipt.
- $25 late payment fee for failure to pay bill within 30 days of date of first billing statement.
- Patient and Guarantor(s) agree to pay all costs of collection associated with collecting the amount owed, including any and all reasonable attorney fees.
- $40 returned check fee for all returned checks.

Insurance Reminder. Your insurance coverage contract is an agreement between you and your insurance company. The amount your insurance company pays is determined under the terms of your contract. You are responsible for any amount not covered under your contract and any pending insurance claims. It is your responsibility to know your coverage plan, what services are covered and which services are not covered.

Copays. Copays are due at the time of service. This is a requirement of your insurance plan. Copays not paid at the time of the visit are subject to a $25 surcharge.

Billing Statements. Please retain a copy of all billing statements; Grow Pediatrics does not guarantee that any statements can be reproduced.

Accepted Payment Forms. We accept cash, check, money order, all major credit & debit cards. When you provide a check as payment, you authorize us to either use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check.

Responsible Party. We hold both parents separately and jointly liable for all outstanding charges if the patient is under 18.

Delinquent Accounts. Failure to pay your bill may result in your account being sent to an outside collections agency and/or being reported to credit reporting agencies. Any delinquent account, including any associated account(s), may be required to pay for any future visit prior to service or may be unable to schedule future appointments until the total balance is paid.

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Print Name	Signature	Date