

ACCOUNT: _____

JAVED I. BANGASH, M.D.S.C. FINANCIAL POLICY

We are committed to providing your child / children with the best possible healthcare. In order to achieve this goal, we need your assistance and understanding of our payment policy.

This is an agreement between Javed I. Bangash, M.D.S.C., as creditor, and the Patient/Debtor named on this form. In this agreement, the words, "you" and "your" refer to the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words, "we", "us", and "our", refer to the offices of Javed I. Bangash, M.D.S.C.

Services: The offices of Javed I. Bangash, M.D.S.C. strive to provide quality comprehensive pediatric care according to the American Academy of Pediatrics standards. Services provided are those that are medically necessary and with the best interest in mind of your child.

Account: Parent / Guardian will be the guarantor of the account. Parent / Guardian full name, address, date of birth, social security number, and photo ID are required to establish an account. Statements are issued at the beginning of each month. If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days. Each insurance plan benefits vary. Some insurance plans may not cover certain services, such as well child coverage, immunizations, procedures. It is your responsibility to know your insurance plan and benefits, as you will be responsible for these items. Delinquent accounts may prohibit us from providing additional services.

Required Payments: Co-payments required by your insurance company must be paid at the time of service, if applicable. We also have a walk-in fee of \$20.00 payable at the time of visit, should you come to the office with your child without a scheduled appointment. This is also non-billable to your insurance company. Medications obtained from our office must be paid for at the time of visit. We will provide you with a copy of the Routing Slip to serve as your receipt for each date of service. No discounts can be taken from the original amount charged.

No Health Insurance: Payment in full is due at the time services are rendered.

Insurance: We will bill your primary insurance company if we are contracted with your insurance. You agree to pay any portion of the charges not covered by your insurance plan. It is your responsibility to make sure our office has the correct insurance billing information on file for your account. The Receptionist will confirm your information at the time of sign in. Promptly advise us of any changes in your insurance coverage or other demographic information (change of name, address, phone number). Should you belong to a contract POS, HMO plan, or Medicaid, your child must be assigned to one of our providers or you will be required to pay at the time services are rendered.

Returned Checks: There is a \$20.00 fee for any checks returned by the bank.

Missed Appointment / No Show Fee: Patients who fail to keep a scheduled appointment, or cancel with less than 24 hours notice, will be charged a \$35.00 fee.

Past Due accounts: If your account becomes past due, we will take necessary steps to collect this debt. Failure to make a payment on your account will result in a \$10.00 service charge each month. If we need to refer your account to a Collection Agency, collection charges will be added to your account. If we need to send your account to a Collection Agency, you may be dismissed from our Practice. You understand if your account is submitted to a Collection Agency or reported to a Credit Reporting Agency, the fact that you received treatment from our office may become public record.

Divorce: In case of divorce/separation, the parent or legal guardian who brings the child to the office is the person responsible for the charges. We cannot become involved in or decipher divorce decree.

Transferring of Records: You will need to fill out a records release form, and pay a fee of \$20.00 per record (maximum of \$50.00 per family) for a copy of their complete medical records. If you need just a copy of the child's immunization record, it will be provided to you at no charge.

Effect Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. Should you have any questions about the above information or any uncertainty regarding insurance coverage, Please do not hesitate to call us at 847-742-9698. We are here to help you. Parent / guardian hereby agrees and consents to the policies set forth above. By executing this agreement, you are agreeing to pay for services that are rendered.

Signature of Parent / Guardian

Date