

CARTERSVILLE PEDIATRIC ASSOCIATES, P.C.

FINANCIAL POLICY:

1. All insured co-pays are requested in full at the time of registration
2. All balances after insurance are requested in full within 30 days of Insurance payment determination
3. Patients must provide all information requested by the insurance Company within 10 business days of the request or the account will be collected as self pay and a refund processed if insurance approves at a later date
4. Credit balances under \$20.00 will not be processed as a refund. We will apply such credits to any future balances that are due
5. All office visits and/or procedures must be paid in full at time of Service in the following situations:
 - No proof of insurance coverage (must present card at time of each visit)
 - Incorrect Primary Care Provider on card
 - Self-pay patient

Please indicate that you understand and accept this policy with your signature.

SIGNATURE _____
Patient/Guarantor Signature

DATE _____