PEDIATRIC HEALTHCARE, L.L.C.
4700 Woodmere Boulevard
Montgomery, Alabama 36106

It is our desire that the provision of healthcare to your family be as efficient and pleasant as possible. Please take a moment to review this information relating to payment for medical services.

Please understand that our service agreement is with you and not with your insurance company. We are happy to assist you with filing for maximum benefits, but you are ultimately responsible for payment for the services you receive. If your insurance coverage changes it is your responsibility to notify our staff upon your first visit to our office after the change. You will become responsible for all charges incurred if our staff has not been notified of changes in insurance status. All co-payments are due at the time services are rendered, regardless of who brings the child for medical treatment. There will be a $20 accounting fee applied to your account if the co-payment is not made at the time of service. If the payment is not received from the insurance company within 45 days, the balance will be turned over to you. In case of disputed claims after you have contacted your insurance company, we will be glad to provide assistance.

Blue Cross Blue Shield: If you are a member of a BlueCross BlueShield plan, in which we participate, your deductible or co-payment is required at the time of service. You are also responsible for notifying us if a referral or pre-certification is required by your insurance company.

Other Commercial Insurance: Payment at the time of service is required for all office charges. To assist you in seeking reimbursement from your insurance company, we will provide you with an itemized statement containing all the information necessary to process your claim.

Special Circumstances: We know that in marital separation and divorce situations, problems with financial responsibility commonly arise. Alabama state law however, holds both parents are responsible for the medical care of their children. We require full payment of co-payments and non-covered charges at the time services are rendered. We will be happy to provide you with a receipt of payment.

Charge Cards: For your convenience, we accept payment by Visa, MasterCard, Discover and debit cards.

Returned Checks and Delinquent Accounts: The maximum fee allowed by Alabama state law will be charged for returned checks. A chronically delinquent account status may result in your family being dismissed from our practice and referred to a collection agency where you will be responsible for all costs incurred.

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to the listed physician for services rendered, which are covered under my health insurance policy(s). If the insurance company should inadvertently send payment to me, I have 5 days to remit payment to the Pediatric Healthcare office.

Responsibility for payment: I understand that I am responsible for all charges not covered by my health insurance carrier, and agree to pay for them. I am responsible for all charges.

Agreement to pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

Express Prior Consent to Contact Consumer by Cell Phone:
You agree, in order for us to service your account or to collect monies you may owe, Pediatric Healthcare, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

1/We have read this disclosure and agree that Pediatric Healthcare, LLC, its employees and/or agents may contact me/us as described above.

Patient Name: _____ Date: _____

Responsible Party Printed Name: _____

Responsible Party Signature: _____

Email Address: _____

Revised 10-2016