1-2-3 Pediatrics
3925 75th Street, Suite 105
Aurora, IL 60504
Phone: 630-978-PEDS(7337)
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# 1-2-3 Pediatrics Payment Policy

The term "you" will refer to the patient or the patient's representative.

Thank you for choosing us for your general pediatric care. We are committed to provide you with quality and affordable health care. We have developed a payment policy regarding patient insurance responsibility for services rendered. Please read this policy, ask us any questions that you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans. If you are not insured by a plan we do business with, then payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an updated insurance card, then payment in full for each visit is required until we can verify your coverage. The responsibility of knowing your insurance benefits is yours. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Non-covered services.** Please be aware that some and perhaps all of the services you receive may be not covered or not considered reasonable or necessary by insurance companies. If any non-covered services were rendered, then you are obliged to pay for these services in full at the time of the visit.
4. **Proof of Insurance.** All patients, or those on behalf of the patient, must complete our patient information form before seeing the doctor. We must obtain a copy of a photo ID and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, then you may be responsible for the balance of a claim.
5. **Claims Submission**. We will submit your claims and assist you in any reasonable way to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Coverage changes.** If your insurance changes, please notify us before or during your next visit, but not afterwards, so we can make the appropriate changes and submit your claim to the correct, updated insurance company, to avoid delays. If any delays beyond 60 days occur in receiving payment from the insurance company, then the balance will automatically be billed to you.
7. **Nonpayment**. If your account is over 90 days past due, then you will receive a letter stating that you have an allotted number of days in the letter to pay your account in full. Partial payment plans will not be accepted unless otherwise

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negotiated. If you do not pay your amount in the allotted time given or any noncompliance with a partial payment plan, then we may refer your account to a collection agency, and then any patient, along with the patient's family members, may be discharged from this practice. If this occurs, then you will be notified by mail that you have 30 days to find an alternative healthcare provider. During that 30-day grace period, our healthcare provider will able to treat you on an emergency basis only.

8. **Bounced Checks**. If there is a payment by check that does not clear, resulting in a "bounced check," then you will be charged, in addition to the original payment amount, the penalty from the banking institution for "bounced checks" plus an additional $10.
9. **Rendered Service**. Again, it is our policy to collect the co-payment before the healthcare provider sees you. Also, if there is any outstanding balance on your account, then this amount is expected to be paid in full in order to be seen again by the provider, even if you have a partial payment plan.
10. **Addendums/ Modifications.** All policies are permanent and may change from time to time. We will keep you updated with any policy changes to this Payment Policy, as addendums/modifications are made.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area, mainly dictated by most insurance companies reimbursements.

I have read and understand the payment policy and agree to abide by its guidelines.

_____
Signature of patient or responsible party

_____
Print Name of patient or responsible party Date