Financial Consent

Shukla Pediatrics is committed to providing the highest quality health care for our patients. As part of your relationship with us a clear understanding of our financial policy is important so you will know what actions will be undertaking on your behalf as well as what your financial responsibilities are.

Health Insurance: Your health insurance policy is a contract between you and the insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs. You are required to: • present your insurance(s) card at every visit • inform us as soon as possible if your insurance carrier changes and provide us with a copy (front and back) of your new card • Due to filing limits we will not be able to process a visit to insurance if that insurance information is provided to our office more than 60 days from the date of service. We do not bill any secondary insurance.

Co-Payment: Co-payments are a contractual obligation between you and your insurance company. All insurance companies require that all co-pays are payable at time of service.

Balance Billing: There are times when your insurance does not cover a charge. Shukla Pediatrics reserves the right to bill you for any allowable non-covered charge, otherwise known as balance billing. **Any claims or services that are denied by your health insurance; patient is responsible for any unpaid fees.**

Failure to Pay an Outstanding Balance: Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without you contacting our billing department to discuss payment options, the account will be turned over to a collection agency.

Uninsured / Self-pay: If a patient is either uninsured, or if we are not listed as the primary care physician on the insurance or presents with an insurance plan that we do not participate with, payment will be due at the time of service.

Returned Checks: Shukla Pediatrics accepts personal checks as a form of payment. Checks that are returned from a bank for non- payment of any reason will incur a fee of $20.00 plus the amount of the check. If the patient has two returned checks in a 12-month period, they will be placed on a cash or credit card only basis.

By signing, I accept and agree to the above Financial Consent. I am aware that I will be considered the "Financial Guarantor" and will be responsible for any patient balances. We welcome the opportunity to discuss any aspect of our financial consent policy. Please ask to speak with the Billing Manager if you have any questions, comments, or concerns. We thank you for your support and look forward to serving you in the future. * Do not sign if you are not the legal parent and/or legal guardian of a minor child seeking services.

Parent/Guardian Signature: _____ Date: _____