Fall Hill Pediatrics
2300 Fall Hill Avenue, Suite 290
Fredericksburg, VA 22401
Phone (540) 899-2555 Fax (540) 899-3554
Claudia Sussdorf, M.D.-Jacinta Topps, M.D.-Sita Canady, M.D.- Verne Rochford, M.D.
Sherie Horvath, M.D.

Billing and Collection Procedures

Our billing department will apply on your behalf for the coverage of medical services provided by this medical facility, by submitting your claims to your insurance company. Our billing department may be required to release necessary medical information to your insurance company, to determine the insurance benefits of which you may be entitled, in order to process you claims. This is a courtesy that may be withdrawn, if your insurance company becomes uncooperative in making payments.

Although we will make every attempt to receive verification of coverage before services are provided, our office **DOES NOT** guarantee that your insurance company will pay for provided medical services. It must be **FULLY** understood that your insurance contract is between you and your insurance company and it is your sole responsibility to know and understand what is/is not covered by your medical insurance policy.

You understand and agree that if it is determined that your insurance is not in effect on the date services are provided, or if your insurance claim is denied for any reason, **you will be financially responsible for all total amounts due on your bill** and you agree to pay all existing and future indebtedness to this medical facility for medical services that may not be covered by your medical insurance company.

If there is a pending insurance claim, you will continue to receive monthly statements from this medical facility listing all charges, payments, adjustments and the current amount due. Charges on the statement will reflect services provided within this medical facility **ONLY**, and will **NOT** reflect any charges from Mary Washington Hospital, or for services provided by other medical physician's facilities.

There is a $40 non-sufficient fund charge for all returned checks and a $50 no show charge for appointments missed without a 24 hour cancellation notice. Three no shows or missed appointments are grounds for dismissal from this medical facility.

By Signing Below…

You authorize our billing department to apply on your behalf for the coverage of medical services provided by this medical facility, and you authorize our billing department to release required medical information to your insurance company in order to determine insurance benefits of which you may be entitled.

You authorize your insurance company to disperse payments to this medical facility for covered medical services and you acknowledge that either you or your insurance company may revoke this authorization at any time in writing.

You understand and agree that in the event your account is referred to Walter Sheffield for collection, you will be financially responsible for all attorney and commission fees and you agree to pay for any such additional fees and/or charges.

You attest that the medical insurance information that you have provided to this medical facility is accurate, you attest that you have thoroughly read, understand and agree to all statements as described herein and you pledge to abide by and be bound to all statements of this Billing and Collection Procedures agreement.

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date