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Billing and Collection Procedures

Our billing department will apply on your behalf for your 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 your 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 This is a courtesy that may be withdrawn, if your insurance company becomes uncooperative in making payments.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.**

(Initial Each)

_____ 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 \$15 non-sufficient fund charge for all returned checks and a \$30 No Show charge for appointments missed without a 24-hour cancellation notice. **Three No Shows/missed appointments are grounds for dismissal of your family from this medical facility.** We ask for 48-72 hours for any medical forms to be filled out or refill requests on any prescriptions.

_____ 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 our collections agency 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.**

By Signing Below – 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)