FALL HILL
PEDIATRICS
1123 Heatherstone Drive • Fredericksburg, VA 22407 • Phone (540)899-2555 • Fax (540)899-3554
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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 This is a courtesy that may be withdrawn, if your insurance company becomes uncooperative in making payments.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.**

ADDITIONALLY:

(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.

_____ There is a $15 non-sufficient fund charge for all returned checks and a $75 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 3-5 business days for any medical forms to be filled out and 24-72 hours for refill requests on any prescriptions.

_____ 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 acknowledge that any balance unpaid after 60 days is considered “past due” and will require a 10% collection at the time of service until all past due balances are paid in full. If a balance is left unpaid, and no attempts to pay have been made, you are subject to dismissal from this medical practice.

_____ **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.**

---------- **You understand and agree to possible additional charges incurred at preventative visits due to a problem/concern identified.**

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/Patient) (Signature of Parent/Guardian/Patient)

_____

(Date)