



PANORAMA PEDIATRIC GROUP FINANCIAL POLICY

**By signing below, I/we understand and agree to:**

Provide correct insurance information and will make sure that the correct Primary Care Provider is listed with my insurance company. It is my responsibility to understand my coverage, benefits and limitations set forth by my insurance company. Bring an up-to-date insurance card and photo I.D. to each appointment.

Payment will be collected at the time of visit for all copays/deductibles/balances due from the parent or guardian who accompanies the child, regardless of any other financial/legal arrangements dictating who will pay. Uninsured patients will be expected to make a payment of \$80 at the time of visit for well and sick appointments. Other insurance carriers where allowed costs are not available, will be expected to pay \$80 towards sick visits.

A \$15 service charge will be added to your account if payment is not made at the time of service or within 24 hours of your visit. There will be an additional \$5.00 billing fee added to my account every 30 days for failure to make payment or payment arrangements with the Business Office (#585-381-4982).

If my child requires lab work that is sent to an outside lab, I understand that I will be billed separately by the lab.

I will be prompt for all appointments. Missed or canceled appointments with less than 24 hour notice will result in:

- First time you will receive a reminder letter.
- Second and future missed appointments will incur a \$50 charge.
- In addition, multiple missed appointments may result in discontinuation of care, subject to review by your physician.

I understand that in the event a check is returned for insufficient funds, a service charge of \$25 will be added to my account.

**Financial hardship should never stand in the way of medical care. Since open communication can benefit both parties, any financial hardship should be discussed with the Business Office (#585-381-4982) so that payment arrangements can be made as early as possible.**

I HAVE READ, UNDERSTAND AND AGREE TO THESE TERMS AND CONDITIONS. I UNDERSTAND THAT FAILURE TO COMPLY WITH THESE TERMS MAY RESULT IN TERMINATION OF CARE FROM PANORAMA PEDIATRIC GROUP.

Patient Name \_\_\_\_\_  
(Please print) Date of Birth \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_  
(Please print)

Parent/ Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Signature)