East Louisville Pediatrics

4171 Westport Road
Louisville, KY 40207
Office: 502-896-8868
Fax: 502-895-6278

6112 Crestwood Station
Crestwood, KY 40014
Office: 502-896-8868
Fax: 502-895-6278

PATIENT FINANCIAL AGREEMENT

PATIENTS LEGAL NAME: _____ **DATE OF BIRTH:** _____

OTHER PATIENTS IN PRACTICE LEGAL FIRST and LAST NAMES INCLUDING DOB, SEPARATED BY COMMA:

_____

_____

_____

Co-PAYMENTS:

Co-payments are due at the time of service. If you are unable to remit your co-payment amount, the office reserves the right to reschedule your appointment for another day/time that is convenient for you. If you wish to be seen at your regularly scheduled appointment, the practice reserves the right to bill an additional $20.00 fee, if the copay is not remitted by the end of the business day.

PRIOR BALANCES:

Prior Balances are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment at the time of the scheduled appointment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the office reserves the right to reschedule your appointment for another day/time that is convenient for you.

HIGH DEDUCTIBLE HEALTH PLANS:

Due to the recent increase in high deductible health plans, it is now the policy of East Louisville Pediatrics to require a $50.00 pre-payment for any visit scheduled that is not for preventative care. Preventative care services include well visits, immunizations, and yearly wellness visits.

Charges for all visits will be charged to your designated insurance carrier/provider for services rendered by East Louisville Pediatrics providers.

The $50.00 pre-payment will be applied to the account and any remaining balances, as determined by the insurance carrier, will be billed to the responsible party on the account.

INSURANCE CHANGES:

It is the responsibility of the patient/parent/guardian, to notify the office of any changes to your insurance, so that we can correctly file claims, and accurately determine out of pocket costs.

*If the patient does not have an active insurance policy, the parent/guardian is responsible for paying for the services at the time of the visit.

BILLING:

East Louisville Pediatrics bills insurance as a courtesy to out patients. If we receive denial information from your insurance payer, you may receive a bill from our office. It is the responsibility of the patient/parent/guardian to reach out to our billing office and/or the insurance company to discuss the balance.

PHONE CALLS:

Any phone number provided at which I may be contacted, I consent to receive calls or text messages, included but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. Calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication for the office, affiliates, contractors, servicers, clinical providers, attorneys, or its agents including collections agencies.

COLLECTIONS ACTIVITY:

If East Louisville Pediatrics does not receive prompt payment, we reserve the right to transfer your balance to outside collections after 90 days. If an account is referred to outside collections, we reserve the right to dismiss the patient/family from the practice. The account is subject to additional fees related to the collections activity.

******Your signature indicates your understanding and compliance with this policy.******

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Print Patient/s Legal Name, separated by commas

_____

Patient Signature/Date:
***If Patient is over 18**

_____

Print Parent/Guardian name *If patient/s are under 18 years of age

_____

Parent/Guardian Signature and Date *If patient/s are under 18 years of age