PEDIATRIC PARTNERS, LLC
750 EAST 29TH STREET FREMONT, NEBRASKA 68025
TELEPHONE (402) 753-2900
FAX (402) 753-2926

FINANCIAL PAYMENT POLICY

A. Personal Responsibility.

The undersigned ("I") understand that I am responsible for all medical fees and costs in effect at the time services are rendered regardless of any insurance coverage. I acknowledge that if a patient has no insurance at the time of service, that a payment may be requested. If I cannot make a payment at the time of service, then I understand that I may be asked to reschedule the appointment to such time as insurance is in effect or a payment can be made. Pediatric Partners, LLC ("Clinic") accepts cash, personal checks, VISA, MasterCard, Discover Card, and American Express.

B. Insurance.

I understand that the Clinic, as a matter of courtesy, will file a claim with my insurance carrier. Many insurance plans require a co-payment for office visits. **This co-pay is to be paid at the time of service or the insurance company can demand a refund on monies paid and the whole visit will become the guarantor's responsibility.** If the guarantor is chronically not making co-pay at the time of service we may ask you to reschedule your appointment. To make sure the Clinic has the correct insurance information, I agree to present the insurance used at each visit. I understand that it is my responsibility to review my monthly statement and to contact Pediatric Partners immediately to report any mistakes that may be noted either in billing insurances or posting of payments.

C. Assignment of Benefits.

I assign all benefits to the Clinic and authorize direct payment thereto of all insurance benefits or Medicare/Medicaid benefits to which I or the patient may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits as well as proceeds and benefits accruing under any settlement, structured or otherwise, or award in judgment for injuries and damages caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment, and a photocopy of this assignment shall be as valid as an original. I understand that I am financially responsible to the Clinic as the patient, parent, guardian, conservator, insured or guarantor, for all charges not covered by the above assignment, which charges may include any medical insurance deductibles or co-insurance. I understand to sign as a guarantor means that if the patient does not pay the Clinic for all charges due, I, as the guarantor, will be responsible for such payment.

D. Release of Medical Records.

I authorize the Clinic and any physician, physician assistant, nurse or office personnel thereof to release any medical information about the patient necessary to determine any benefits which may be payable for services provided.

E. Coordination of Benefits.

I acknowledge and authorize the Clinic to coordinate benefits between multiple potential payers but understand that it is the Insured, Parent, Guardian, Conservator, or Guarantor's responsibility to reply to any inquiries from insurances and that I may be billed for balances that insurance denies due to this reason.

F. Payment Arrangements:

I understand that I am responsible for contacting the Clinic's Patient Accounts Representative at (402) 753-2900 and making payment arrangements on all balances due. I agree that all accounts must receive payments every thirty (30) days to remain in good standing and avoid collection efforts.

G. Interest Charges:

I understand that accounts with open balances over ninety (90) days old will be subject to interest charges of 1.5% on all open balances, all interest charges are calculated per patient per 30 days.

H. Patient Statements:

I understand that the Clinic utilizes "Guarantor Billing", that is all patients listed under one guarantor will receive one statement per month. Furthermore, the clinic cannot and will not provide separate statements (i.e. separation/divorce). Statements are generated monthly for all accounts with balances greater than $4.99, if an account has a balance less than $4.99 the clinic will generate these statements bi-annually in June and December.

I. Collection Agency.

I understand that delinquent accounts with no activity for sixty (60) days will be subject to collection efforts which include: phone calls, and letters. If these in-house collection attempts fail the account may be turned over to the Clinic's collection agency. I agree that a $12 fee will be added to any accounts that have been turned over to the Clinic's collection agency. To avoid this action, I understand I can contact the Clinic's Patient Accounts Representative to arrange for a payment arrangement to address the delinquency.

J. Dismissal from practice:

I understand that accounts that file bankruptcy two (2) times will be dismissed from the practice and any accounts given to a collection agency two (2) times, will be dismissed from the practice. This will cover all patient accounts listed for the insured, parent, guardian, conservator or guarantor.

K. Acknowledgment.

I acknowledge that if I have any questions regarding the above Financial Payment Policy, I can contact the Clinic's Patient Accounts Representative at (402) 753-2900. I have read this Financial Payment Policy, have had any questions addressed and agree to the terms thereof.

_____	_____
Signature of Insured, Parent, Guardian, Conservator or Guarantor	Patient Signature (if over 19 years)
_____	_____
Printed Name of Insured, Parent, Guardian, Conservator or Guarantor	Patient Printed Name
_____	_____
Date	Date