Casa Grande Pediatrics
Finance and Practice Policies

Welcome to our practice. The following is an explanation of our financial policies regarding patient accounts. Please take a few moments to read these policies, as it will describe your responsibilities for the handling of your account.

It is the responsibility of the (Parent/Guardian) to inform us on the day of service who their primary insurance carrier is and if any secondary coverage exists. If the information given to us is incorrect the (Parent/Guardian) will be responsible for any and all charges incurred on that date.

HMO/PPO Plans

The co-payment and deductibles are due at the time of service, **before** you see the provider. If you are unable to pay your co-pay or deductible at the time of service you will be asked to reschedule your appointment for a different day. If your plan requires a written referral from your primary care physician, we ask that you obtain the referral prior to your schedules appointment.

Third Party

We do not accept liens as payment. You are responsible for payment at the time of service.

Other Insurance Plans

As a courtesy to our patients with private insurance, we will file the insurance claims. However, you will be responsible for payment if your insurance company has not paid within 60 days with a reasonable cause.

Self-Pay

If you are a self-paying patient, you will be required to pay for your office visits and procedures at the time of service. Fees for surgery are to be paid prior to the surgery.

Our goal is to deliver quality medical care. Please ask for assistance if you have a question or comment about our fees or financial policies.

If you are a walk-in patient please be advised that scheduled patients will be seen first. Please be patient, there could be a long wait. If your child is in need of immediate care please notify the front desk, and a decision will be made as to whether the provider can see them or you will be asked to go to the emergency room at the hospital.

I certify that I have read and fully understand the financial policies of Casa Grande Pediatrics. I realize that I am responsible for my charges and that any collection or attorney's fees will be charged to me in the event my account is not paid in full as described in the terms and conditions above. I understand there is a $25.00 charge on each returned check.

Signature of Patient/Parent/Guardian

_____ Date: _____