702 WAKE AVE
EL CENTRO, CA 92243
760-352-7216

FINANCIAL POLICY

Thank you for choosing ***Adolescents Babies and Children Pediatric Medical Group Inc***. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment.

We do require payment for co-pays and deductibles at the time of service. All patients must complete our information and insurance form before seeing the doctor. We cannot bill your insurance company unless you give us accurate insurance information. Your insurance policy is a contract between you and your insurance company. We are not part of your contract, if your insurance company has not paid your account in **full within 45 days**, the balance will automatically become your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. So be sure that you read your policy. In the event that your insurance coverage changes to a plan where we are not a participating provider, please contact your insurance to inquire about the change on coverage.

Parents or guardians of the minor are responsible for full payment. In the event that someone other than the parent or guardian accompany the minor, they will be required to pay for the services such as co-pays and deductibles at the time of service. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy and understand and agree to this policy.

Full payment is due at the time of service. We accept cash, checks and/or VISA/MASTERCARD.

In consideration for professional services rendered or to be rendered, and for credit extended. I agree to pay for any office charges incurred within 45 days of the service date.

Furthermore, if any any hospital physician services are provided, I agree to pay the hospitalization charges within 60 days, unless written arrangements modifying this agreement are made between the physician and myself if a collection service or other collection procedures are required for collection of the office charges and /or hospital physician charges. I also agree to pay all additional cost of collection of the office charges and/or the hospital physician charges, including reasonable attorney fees and interest charges.

I fully understand that the medical records of my children will be send to storage after five years of their last office visit, unless I request transfer of said record to another physician. I agree to pay the registered postage and /or storage fees of the records transfer, if such charges applies.

Signature of responsible party/Parent:____

Relationship with the patient:____________________________________ Date:__________________