CARROLL CHILDREN'S CENTER

PATIENT'S FINANCIAL RESPONSIBILITY DISCLOSURE
(Please read carefully)

Patient Name:_____ **Date of Birth:**_____

At the present time, _____is my insurance carrier. I will inform Carroll Children's Center (CCC) of any changes with the above insurance carrier. I certify that I am not enrolled in any Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) that is not contracted with Carroll Children's Center.

As a courtesy, Carroll Children's Center has agreed to file a claim for services rendered with my insurance carrier. I am responsible and expected to pay Carroll Children's Center for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier
5. Any charge/fee established by Carroll Children's Center for forms and missed co-pays

If Carroll Children's Center has not received payment from my insurance carrier within 60 days from the date of service, I may be expected to pay my balance in full. I am responsible to be sure that all charges are paid, whether by me or my insurance carrier, as my insurance policy is a contract between me/my employer and the insurance company. CCC is not a party to that contract. *Please be aware that some and perhaps all of the services provided may be considered non-covered or not reasonable and customary charges under your medical plan, and may become your responsibility*. Further, the adult accompanying a minor and/or the parents (or guardians) of the minor are responsible for payment.

Patients Without Insurance: Payment in full is due at the time of each service. If you are unable to pay the entire balance at the time of service, you will be required to pay a $50 deposit and sign a Promissory Note making arrangements for a payment plan. The $50 deposit does not cover the office visit for that day; it only covers a portion of the charges. Additional Services may be billed after the visit based on diagnostic tests completed during visit deemed necessary by the physician.

I understand that payment is required at the time services are rendered unless other arrangements have been made with the Billing Department in advance. Carroll Children's Center accepts cash, personal checks, VISA, MasterCard, Discover and American Express. *There is a service charge for returned checks for any reason for the fee charged to us by our bank. And further, the office reserves the right not to accept future checks if any checks have been returned previously.*

I understand that I may be subject to a **"Late Fee"** of $10.00 per month if my account balance is not paid within 30 days of receipt of my first statement. Carroll Children's Center reserves the right to charge this fee on unpaid patient balances at the rate currently allowed under Maryland law.

Regardless of insurance coverage, if after default, my account is placed in the hands of an attorney or collection agency for collection, I agree to pay a service charge of 25% of the unpaid balance and all attorney and/or collection fees, together with all additional costs and expenses of collection to the present extent of the law.

Excessive abuse of scheduled appointments may result in discharge from Carroll Children's Center

I HAVE READ THE ABOVE INFORMATION AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY CARROLL CHILDREN'S CENTER.

Patient's Name (Please Print) **Patient's Signature/Date**

As Parent/Guardian of the above referenced individual, I will continue to be responsible for all cost incurred for the services rendered up to the age of 18.

Parent/Legal Guardian (Please Print) **Parent/Legal Guardian Signature/Date (Seal)**