

Patient Financial Agreement

Families First Pediatrics

1268 W. South Jordan Parkway, Suite 201

South Jordan, UT 84095

(801)254-9700

As the patient's financial representative, you understand and agree to the following:

- Payment and/or copay is due at the time of service. If copay is not paid at the time of service a \$10.00 fee will be assessed to the account.
- A \$25.00 fee will be assessed on all returned checks.
- You are responsible for the account balance after 60 days regardless of insurance coverage.
- You are responsible for knowing your insurance coverage and benefits. **It is your responsibility to make Families First Pediatrics aware of any charges not covered by your insurance, including all immunizations.** As a courtesy, Families First Pediatrics will bill your insurance and allow them 45 days to make payment. After 45 days it is your responsibility to follow up with your insurance.
- You authorize care and treatment by Families First Pediatrics and release of all information to insurance and third party carriers and direct them to remit payments directly to Families First Pediatrics.
- If your account is in good standing with no past history of collections or bankruptcy, Families First Pediatrics will extend credit on your account for a maximum of 6 months with a minimum monthly payment of \$50.00 or 1/6th of the account balance, whichever is greater.
- Accounts past 90 days will be charged interest at a rate of 1.5% monthly(18% annually). A late fee of up to \$20.00 per month may be charged to past due accounts.
- If the account is assigned to an agency for collections, it is agreed that the financial representative will pay all attorney fees, with or without suit, court costs, and a collection fee of up to 40% of the balance, which will be added to the outstanding balance of the account.
- Self pay patients will receive services at a discounted rate if charges are paid in full at the time of service. (The discounted rate will be between 20-30%)
- A notice of 48 hours for canceled appointments is appreciated. A \$25.00 charge may be assessed to the account if there is an excessive amount of missed appointments without notification.

Signature of Financial Representative: _____

Printed Name: _____ Date: _____

Drivers License Number: _____

Patient name(s): _____

Relationship to Patient: _____