# Durant Road Pediatrics
# Financial Policy

It is your responsibility to keep us updated with your correct insurance information. Please bring your insurance card to every visit. Please be aware of your insurance requirements.

**Payment options**: You can choose to pay your copay, deductible or account balance by cash, check or credit card. Copayments must be made at the time of service.

**Self-pay**: Patients without insurance coverage will be required to pay for all services at the time services are rendered. Payment plans available for self-pay patients.

**Copayments, deductibles and fees**: Copayments must be paid at the time of service. Insurance coverage is not a substitute for your financial obligation for services rendered. You are responsible for payment of any services that are not covered by insurance, including, but not limited to copayments, deductibles, and non-coverage of services. It is your responsibility to know if your insurance requires a referral and/or preauthorization to see a specialist or prior to having a procedure and what services are covered. Failure to do so may result in a lower payment from the insurance company.

**Out of network/non-participating insurance carriers**: If your insurance carrier considers us "out of network" or does not participate with us, you are responsible for payment in full at the time of service. We charge what are usual and customary rates for our area.

**Returned checks**: There is a fee of $30 for any checks returned by the bank.

**Past due payments**: lf your account becomes delinquent (past due 60 days) you may be subject to interest, rebilling fees and collection costs. Should collection action become necessary you will be required to pay an additional 20% collection fee, all legal fees, with or without suit, including attorney fees and court costs.

*I authorize Durant Road Pediatrics, PLLC or their assigned designee to file insurance claims for all services provided to my dependents and payment for those services to be made directly to the provider.*

Signature: _____ Date: ___/___/_____

Printed Name: _____