HYDE PARK PEDIATRICS
3330 ERIE AVE, CINCINNATI, OHIO 45208
513-321-0199 (p) 513-979-0569 (f)
7661 MONTGOMERY RD, CINCINNATI, OHIO 45236
513-891-9595 (p) 513-891-7696 (f)
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FINANCIAL AGREEMENT

Our Goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask our staff.

- On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.
- If your insurance company has not been informed that we are your primary care physicians as of the service date, you may be financially responsible for the cost of the visit.
- According to your insurance plan you are responsible for any and all co-payments, deductibles and coinsurance amounts.
- Co-payments are to be paid at the time of service.
- It is your responsibility to understand your benefit plan.
- If our physicians do not participate in your insurance plan, payment is expected from you at the time of your office visit.
- If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be billed to responsible party. Any balance over 60 days may require collection agency proceedings.
- We require 24-hour notice for cancelling any appointments. There is a $50 no show charge for missed uncancelled appointments.
- A $25.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees that are incurred.
- We charge $15.00 per child to transfer medical records to a new provider.
- I hereby authorize my insurance benefits to be paid directly to Hyde Park Pediatrics, Inc. realizing that I am responsible to pay non-covered services and procedures.

I have read and understand the office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this agreement.

_____	_____	_____
Patients name	Responsible party members name	relationship
	_____	_____
	Signature	Date