

**Hyde Park Pediatrics**  
3330 Erie Ave Ste 11, Cincinnati, OH, 45208  
PH: (513) 321-0199 FAX: (513) 979-0569

## **Financial Agreement**

At Hyde Park Pediatrics, our goal is to establish and maintain good provider-patient relationships. This financial agreement outlines office policies regarding insurance, payments, and billing procedures. If you have any questions, our staff will be happy to assist you.

## **Insurance and Billing**

- Upon arrival, please check in with the front desk and provide your current insurance card(s). This confirms your insurance details and authorizes us to bill your insurance provider on your child's behalf. If incorrect or outdated insurance information is provided, you will be responsible for any charges incurred.
- If your insurance company does not have Hyde Park Pediatrics listed as your child's primary care provider as of the date of service, you may be financially responsible for the full cost of the visit.
- You are responsible for any copayments, deductibles, or coinsurance amounts as determined by your insurance plan.
- Copayments are due at the time of service. Failure to pay at the time of the visit may result in additional billing fees.
- Well-child exams are typically covered by insurance with no copayment. However, if your child receives preventive care services outside your insurance coverage limits, you may be responsible for additional charges.
- If your child receives acute care services during your well-child exam, you will be responsible for a sick-visit copay. It is your responsibility to verify your child's eligibility for an annual exam with your insurance provider.
- If our providers are not in-network with your insurance plan, you are responsible for payment in full at the time of service. Please confirm that we are in-network before your appointment.

## **Outstanding Balances and Collections**

- Any balance not paid within 28 days of billing will become the guarantor's responsibility. If payment arrangements are not made, balances 60 days past due may be sent to a collection agency.

## **Missed Appointments and Fees**

- We require a 24-hour notice for appointment cancellations. Appointments missed without sufficient notice will be subject to a \$50 cancellation/no-show fee.
- A \$25 fee will be charged for any checks returned due to insufficient funds, in addition to any bank fees incurred.
- There is a \$15 fee per child for a complete medical record transfer.

By signing below, I acknowledge that I have read and understand the Hyde Park Pediatrics financial policy. I agree to comply with these terms and accept responsibility for any applicable payments.

Patient Name: \_\_\_\_\_

Guarantor (Print Name): \_\_\_\_\_

Siblings (if applicable): \_\_\_\_\_

Guarantor Relationship to Patient: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_

Date: \_\_\_\_\_