

LAST NAME

ACCOUNT #

## CREDIT POLICY

Thank you for choosing Olson Pediatric Clinic for your child's care.

The following is information regarding our credit policies. Please read it, sign it and give it to the receptionist with the  registration form. If you have questions regarding any of these policies, please do not hesitate to discuss them with our  bookkeeper.

1. A deposit of \$50.00 for sick visits or \$100.00 for well care is required at the time of the first visit. If you belong one of  our contracted managed care plans, this deposit will be waived, provided that a current insurance card is presented.  Co-pays are to be paid at the time of your visit.

2. Balances not covered by insurance are due within thirty days of the initial billing unless prior arrangement have been  made with our credit department; payment plans are available if necessary.

3. The parent or guardian with whom the child resides is ultimately responsible for the payment of the charges incurred  at this facility regardless of circumstances involving divorce, custody, etc.

4. You are responsible for the payment of your balance in a timely fashion, regardless of discrepancies and/or disputes  with your insurance carrier.

5. Persistently delinquent accounts will be referred to an independent collection agency. Should this occur, you will be  asked to seek medical care elsewhere.

Permission is granted to leave message for me on my answering machine and/or with a person answering  the telephone at my residence.

FINANCIAL AGREEMENT: The undersigned agrees, that in consideration of services to be rendered to the patient,  he/she assumes financial responsibility for this account under the terms and conditions as listed above. In further  consideration of services rendered by this clinic, I agree, should my account become 60 days past due, late fees of \$  10.00 per month will be charged on the outstanding balance until paid in full.

Patient(Parent or Legal Guardian if Juvenile)

Date