BLUE FISH
PEDIATRICS
www.bluefishmd.com

Patient Financial Responsibility Agreement

Thank you for choosing Blue Fish Pediatrics. We are committed to providing you and your family with the highest quality healthcare. Please read and sign the form to acknowledge your understanding of our patient financial policies.

- The patient is ultimately responsible for the payment of his/her treatment and care. This includes any and all procedures, developmental questionnaires, and vision/hearing screenings that are performed at the time of the visit.

- The patient is responsible for charges associated with Insurance co-pays, co-insurances, deductibles and or non-covered charges.

- Any outstanding patient balances should be paid at the time of service by either parent.

- For patients WITHOUT insurance benefits, payment is due in full at the time of service.

- Newborn parents should produce proof of insurance as soon as possible.

    - If the child reaches 1 month of age and no proof is provided, and we are unable to verify coverage, the parent/legal guardian will be responsible for the entire bill.

- Statements are mailed out monthly. Failure to make payments within 90 days may result in being notified to find alternative medical care.

    - Payment plans are available. Please inquire with our Billing Department.

- Returned Check policy: If payment is made by check, and the check is returned as Non-Sufficient Funds, or Account Closed, the amount of the original check will be due as well as an additional $35 fee.

By signing below, you are agreeing to and understand the above financial agreement. You are acknowledging that as the parent/legal guardian, you are responsible for any charges incurred and agree to pay as stated above.

Patient Name: _____ DOB: _____

Parent/Legal guardian: _____ Date: _____