
Date

Account number

THE LINCOLN PEDIATRIC GROUP, LLC

FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office. In an effort to prevent any misunderstanding about our financial and billing policies, please take a moment to read this information. We will gladly discuss any questions you may have about this information.

If you do not have insurance, payment is due at the time services are rendered unless alternate payment arrangements are made with our billing staff. To assist you, we accept cash, checks, MasterCard or Visa.

If you have insurance, we will file your primary and secondary insurance for you as a courtesy if you have provided us with your current insurance information, and if you have authorized your insurance company to pay us directly. **You must realize, however, that your insurance is a contract between you and your insurance company. Payment to us is your responsibility.** If, at the end of ninety days, your insurance company hasn't remitted payment to us, payment will be due in full from you. If your insurance company requires co-payments as a part of your plan, these payments are collected upon check-in. Please keep in mind that if a service is not a covered benefit in your insurance plan, you are responsible for the payment to us.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. There is a service charge of \$15.00 for each returned check. We do use outside agencies as a means of collection should we deem it necessary.

In case of divorce, the parent signing this financial policy is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties in a divorce must be dealt with between those parties and does not involve Lincoln Pediatric Group, LLC.

If you have any questions about the above information, please call (402) 489-3834 and ask for someone in the billing department or press option 2. We are here to help you.

AUTHORIZATION: I have read and agree to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claim(s) and authorize payment of benefits directly to The Lincoln Pediatric Group. I understand I am financially responsible to The Lincoln Pediatric Group for charges not covered or denied by my insurance company. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my nonpayment.

Signature of responsible party

Responsible party (please print name)