Willow Tree
PEDIATRICS

P: 256.735.4632 F: 256.735.4639
1167 COUNTY RD 437, SUITE B
CULLMAN, AL 35055

Willow Tree Pediatrics
Financial Responsibility Agreement

You are responsible for all co-pays, deductibles, and coinsurances according to your specific insurance plan. You must pay for the cost of services if insurance does not pay or you do not have active insurance.

Co-pays are due at the time of service. If your insurance plan has a deductible, a minimum $50 payment may be due the day of service.

A $15 service fee will be charged in addition to your co-pay if not paid at the time of service.

There are tests available for collection in this office that will require being sent to an outside lab for interpretation. The outside lab will bill you for these services and you are responsible to pay for them.

Patient balances are billed monthly. We ask that you pay your statement balance after receiving your first statement.

Beginning 1/01/2025, any debit/credit card payment made to Willow Tree Pediatrics that needs to be refunded back to card will have a 3% credit card fee and a $0.60 convenience fee subtracted from refund. There is no fee for payments that originated as cash or check on refunds.

Beginning 1/01/2025, all payment plans will be subject to a $5 monthly fee.
Any accounts that have balances **over 90 days old** will need to set up a payment plan agreement and provide a credit card on file to continue a relationship with Willow Tree Pediatrics.
For scheduled appointments, any outstanding balances that are not set up on payment plans must be paid prior to the visit or you will be asked to reschedule.

Any accounts that have been placed on a payment plan will need to provide a credit card on file to continue a relationship with Willow Tree Pediatrics.

We accept cash, check, and all major credit cards.

A $30.00 fee will be charged for any checks returned for insufficient funds and checks will no longer be permitted as a method of payment.

I have read and understand this agreement and will comply and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Name: _____ DOB: _____

Parent/ Guardian Signature: _____ Date: _____