



Willow Tree Pediatrics  
Financial Responsibility Agreement

According to your insurance plan, you are responsible for all co-pays, deductibles, and coinsurances.

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.

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.

A 20% surcharge will be assessed on all balances over 90 days old.

If previous arrangements have not been made with our finance office, any account balances over 90 days old will be forwarded to a collection agency and all collection expenses will become your responsibility.

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

For scheduled appointments, any outstanding balances must be paid prior to the visit, or you will be asked to reschedule.

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: \_\_\_\_\_