Healthy Days
PEDIATRICS

Dr. Alison Days

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Patient Financial Agreement

(Select one, sign & date below - please ask for assistance if needed)

_____**Option 1: PAYMENT OR DEPOSIT AT TIME OF SERVICE (self pay)** I agree to **PAY IN FULL** or leave a **REFUNDABLE DEPOSIT EQUAL TO THE ESTIMATED CHARGES** for services rendered at Healthy Days Pediatrics **AT THE TIME OF SERVICE**. *This option typically applies to those with no insurance or those who do not have a credit card they are willing to keep on file.* As a courtesy and if applicable, Healthy Days Pediatrics can bill my insurance and will refund me any portion I paid that was covered by insurance.

_____ _____

(signature) (Date)

_____**Option 2: PROMPT PAYMENT PLAN (Insurance Plan)**

I am a patient at Healthy Days Pediatrics that has insurance and would like to have Healthy Days Pediatrics bill my insurance. **I agree to keep a current credit card on file and authorize Healthy Days Pediatrics to charge this card for any unpaid balance that is greater than 45 days from time of service.** I understand Healthy Days Pediatrics will attempt to mail at least one statement prior to charging the card and I understand that I may settle my account at any time prior to the card being charged using a different method of payment. Regardless of the efforts to notify me I agree to have no outstanding balance greater than 45 days from time of service and understand that the card provided will be charged for any outstanding balances incurred. I will pay my co-pay at the time of services and immediately pay any amount that my insurance does not pay.

_____ _____

(signature) (Date)

_____**Option 3: MEDICAID PLAN**

My child is on Medicaid and I agree to notify Healthy Days Pediatrics of any changes. I agree to abide by rules established by Medicaid. Failure to keep information current will result in payments being due in full at time of service.

_____ _____

(signature) (Date)