HERRIN PEDIATRIC CLINIC OFFICE POLICY
CONCERNING FINANCIAL ARRANGEMENTS AND HEALTH INSURANCE

We know that you are concerned about the cost of health care and we want you to know that we are striving to hold down our professional fees. You can help us by selecting one of the following methods of payment for the professional services that you receive from Dr. Herrin:

A. Cash, check, or credit card at the time of treatment.

B. Insurance – giving us a copy of your insurance policy card and keeping us updated on any changes to your insurance coverage. (See below)

All accounts must be paid in full within 90 days. After 90 days, past due accounts will be turned over to a Collection Agency.

PATIENTS WITH INSURANCE

Please remember that you, not the Insurance Company, are responsible for payment of professional services. Please note the following points:

A. Dr. Herrin is responsible for the treatment discussed with you.

B. You are responsible for payment to Dr. Herrin

C. As a courtesy to our patients and at your request, we will be happy to file charges for your office visit and hospital services performed by Dr. Herrin with your Insurance Company. We have been instructed by ALL Insurance Companies that pre-certification and filing DOES NOT GUARANTEE PAYMENT. The determination of whether that bill is paid is made by the Insurance Company when they receive the claim. **If your insurance has not paid within 60 days, then you are responsible for the balance.**

D. When payment from the Insurance is received, **you are responsible for the prompt payment of any remaining balance.** Any overpayment will be promptly refunded to you.

I certify that the answers to health questions are correct to the best of my knowledge; also, I grant to the physician and staff to perform all procedures and treatments that may be necessary. **(This includes minor consent.)** I authorize release of information to my Insurance Company and for payment of benefits to **James R. Herrin, M.D.**

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's condition including blood tests, x-rays, developmental testing, and any other pertinent tests performed by Dr. Herrin.

I understand that I am responsible for any balance due on my account. Finally, I agree to pay collection costs and attorney's fees if collection procedures become necessary of a delinquent account.

Signature_____ **Date**_____