WEE PEDIATRICS, INC.
THERESA Y. WEE, M.D.

Financial Policy and Waiver

Your insurance policy is a contract between you and your insurance company. We at Wee Pediatrics, Inc. cannot bill your insurance company unless we receive from you, your current valid insurance information including a copy of your valid insurance card. It is your responsibility to notifying our office of any changes in your insurance status such as a change in plan or benefits as soon as they occur. Any costs incurred by this office because of incorrect information provided to us by you or your representative will become your financial responsibility. As a courtesy, we will file claims with those plans with which we have an agreement. If your insurance company does not pay is within a reasonable time, we will look to you for full payment of services rendered.

Not all plans are the same, and they do not cover the same services. In the event your insurance company determines a service provided was "not covered" or not a covered benefit, you will be responsible for the total charges. This office is not responsible for disputing insurance company decisions regarding coverage. Payment is due upon receipt of a statement from our office. We expect that you know your insurance coverage and benefits, including but not limited to: deductible, co-payment amount, laboratory services, radiology facilities and hospitals associated with your plan.

If you are covered by an insurance company or plan that we are not contracted or do not participate with, or you have no insurance coverage, our charge for your care or the care of your dependents will be due at the time of service. Our office accepts all major credit cards, debit cards and checks. All co-pays are due at the time of service. If you are unable to pay your co-pay at the time of service, a rebilling fee may be applied to cover the cost of processing a statement.

I understand that I must notify the office immediately of any insurance changes or other circumstances that would affect the billing of my services. Wee Pediatrics, Inc. strongly encourages you to call your insurance company to verify your coverage and benefits prior to your visit.

I hereby authorize Wee Pediatrics, Inc. to release any information to my insurance company for payment of medical charges and/or to review activities related to my healthcare provider's participation with my health care plan. I assign to Wee Pediatrics, Inc. any and all benefits to which myself or my dependants is entitled for medical services rendered.

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Patient Name (Print) Date of Birth

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Signature of Patient or Responsible Party Date

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Printed Name

______________________________ ______________________

Wee Pediatrics, Inc. Staff-Witness Signature Printed Name

Thank you for allowing Wee Pediatrics, Inc. to participate in your health care needs.