F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.
1212 McCONVILLE ROAD
LYNCHBURG, VA 24502

OFFICE FINANCIAL POLICY

Important Information regarding Financial Policies, Payment Information, and Insurance Filing.

PLEASE READ CAREFULLY AND SIGN BELOW

Thank you for the confidence you have displayed in us by allowing F. Read Hopkins Pediatric Associates, Inc. to be your child's health care provider. As the physicians provide the medical care your child needs, we, the members of the staff, are available to assist you in understanding our office policies. The following information regarding the financial policy of the practice is important and represents a refinement of past procedures.

Our office financial policy requires payment in full for all medical services rendered at the time of the visit.

We will be happy to assist you in filing your claim with your health insurance plan so that the claim can be resolved promptly. If the patient is covered by one of the health insurance plans with which we participate, we are required by the plan to collect co-payments and deductibles at the time of service. It is imperative that you bring your insurance card and mailing address of your health insurance plan with you to every visit, making us aware of any changes in your coverage. Failure to provide us with current insurance information could result in a reduction of your benefits and higher out-of-pocket costs for you.

In order to facilitate prompt payment, we offer several forms of payment. These include cash, check, money order, debit transactions, VISA, MasterCard, and Discover.

I understand and agree (by signing below) that I(we) am(are) directly and fully responsible to F. Read Hopkins Pediatric Associates, Inc. for current payment of all medical bills for services rendered. In the event it is necessary for F. Read Hopkins Pediatric Associates, Inc. to turn an account over to its collection agent, then I agree to pay all cost of collection including a thirty-three and one-third percent (33 1/3%) attorney's fee, court costs, including service of process cost, and interest until my account is paid in full.

I hereby authorize payment of medical benefits directly to the physician and/or supplier and to release any information required to process insurance claims.

We invite you to discuss frankly with us any questions or concerns regarding our services or policies.

Sincerely,

Angela P. Hawkins

Angela P. Hawkins
Administrator

Signature of Parent or Legal Guardian	Relationship to Child	Date
Print Name of Parent or Legal Guardian		
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Print Name of Parent or Legal Guardian		