

Patient Name: _____

MRN: _____

Metropolitan Pediatrics

Credit Policy



Clackamas
9300 SE 91st Ave., Ste. 200
Happy Valley, OR 97086
503.261.1171

Gresham
24988 SE Stark St., Ste. 200
Gresham, OR 97030
503.667.8878

Northwest
1130 NW 22nd Ave., Ste. 320
Portland, OR 97210
503.295.2546

Westside
1960 NW 167th Pl., Ste. 100
Beaverton, OR 97006
503.531.3434

Patients are responsible for all charges resulting from treatment provided by Metropolitan Pediatrics, LLC. Payment is due within 30 days of statement billing unless other payment arrangements are made. You will be responsible for all agency and/or legal fees incurred should your account be placed in a collection status.

INSURANCE: As a courtesy, we will bill most insurance carriers directly. Be advised, this does not guarantee payment and ultimate responsibility of the account is yours. You are responsible for deductibles, copays, non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. Copays are due at the time services are rendered. Failure to pay at the time of service will result in a \$15.00 late fee assessed to your account. If you or your insurance carrier makes payment exceeding your balance, a refund will be issued. Providing accurate insurance information is the responsibility of the parent/patient. Patients are expected to bring their current insurance identification card(s) to each appointment.

Oregon/Washington Welfare and Oregon Health Plan: You may be asked to sign a waiver assuming financial responsibility for services not covered under the State Medicaid Program. Please be advised, Metropolitan Pediatrics, LLC, does not participate with every managed care program.

Workers' Compensation: You will need the name of your insurance carrier, the date of your injury and your claim number, if available. Please notify the front desk if your visit is due to a work-related injury.

Motor Vehicle or other Liability Claims: Metropolitan Pediatrics, LLC, is unable to bill insurance carriers in liability claims. Settlements of these claims can take several months; full payment for the visit(s) or financial arrangements must be made at the time of service.

BANKRUPTCY: Insured Patients: All applicable copays, coinsurance and deductibles will be due at the time of service.
Non-insured Patients: Payment in full is required at the time of service.

DIVORCED PARENTS: Both parents are equitably responsible for their child(ren)'s healthcare expenses, unless a court mandate stipulates otherwise. Disputes between parents will not be arbitrated by Metropolitan Pediatrics, LLC.

RETURNED CHECKS: Checks returned for insufficient funds will result in a \$25.00 fee assessed to your account.

MISSED APPOINTMENTS: If you cannot keep your appointment, please cancel 24 hours prior to the scheduled time or a \$50.00 "no-show" fee may be charged to your account.

AFTER-HOURS APPOINTMENTS: Appointments scheduled outside of the posted office hours are subject to an additional \$25.00 charge per visit. This charge will be billed to your insurance.

ASSIGNMENT OF BENEFITS: I authorize my insurance carrier(s) to remit payment of benefits for any claim to Metropolitan Pediatrics, LLC. I understand that any ineligible or non-covered expenses are my responsibility.

I assign Metropolitan Pediatrics, LLC, as an Authorized Representative to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy and/or settlement information upon written request from Metropolitan Pediatrics, LLC. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement. I agree to and have received a copy of this Credit Policy for my child(ren)'s treatment with Metropolitan Pediatrics, LLC.

Signature of parent or guardian

Print Name

Relationship to patient

Date