Austintown Pediatrics, Inc.

Financial Agreement Regarding Patient/Family Balances

Eff. 2/1/12

I, the undersigned, acknowledge and agree to the following with regard to any Patient/Family Balances incurred as a result of services rendered at Austintown Pediatrics, Inc. (aka "Practice"):

1) All Patient Balances must be paid in full within 90 days of the issue date of the first Patient/Family Statement mailed.
2) Any Patient/Family Balances remaining after 90 days will incur a monthly interest charge of 2.5%.
3) If no payment is received within 60 days of the issue date of the first Patient/Family Statement mailed, a $20.00 Neglected Statement Fee will be charged to the Patient account.
4) If no payment is received with 90 days of the issue date of the first Patient/Family Statement mailed, the Patient/Family account will be sent to Collections **and** the Patient/Family will be dismissed from the Practice.
5) Failure to keep current any Patient/Family account could result in the reschedule/delay of Well Child Checkups and other services, as well as dismissal from the Practice.
6) Contact the Billing Dept. at 330-953-1409 with any questions.
7) The above listed policy does not apply to Self-pay patients.

Print Name of Patient/Patients:____________________________________

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Print Name of Parent/Guardian: ____________________________________

Signature of Parent/Guardian: ____________________________________

Date: ____