Receipt of Patient Responsibility

970 S. Silver Lake Street, Suite 102
Oconomowoc, WI 53066
Ph: (262)569-7100 Fax: (262)567-6295

2750 Golf Rd, Suite B
Delafield, WI 53018
Ph: (262)646-2282 Fax: (262)646-7535

1.It is my responsibility to provide Lake Country Pediatrics, S.C. with current insurance information at the time of service.

2. I am responsible to pay all amounts not paid for or partially covered by my insurance, including, but not limited to: co-pays, deductible, co-insurance, screenings (vision, hearing, M-CHAT, BMI, urine), and/or in-office lab testing.

3. I authorize direct payment from my insurance company to my physician for services rendered.

4. I authorize release of medical information to process claims.

5. It is my responsibility to pay any applicable co-pays at the time of service. Co-payments not paid at the time of service <u>WILL BE SUBJECT TO A $15.00 BILLING FEE.</u>

6. I understand if I have not met my yearly deductible set by my insurance plan, I will be asked for $100 towards my deductible for office visits

7. I understand if my child does not have health insurance, I can pay a self-pay discount fee of $150 at the time of service.

8. I am responsible for paying all amounts due within 10 business days of receipt of my billing statement.

9. It is my responsibility to contact the billing department within 10 business days of receipt of my statement to make a payment arrangement for all balances not paid in full.

10. I understand that if my account is 60 days or more past due, there will be a 17% APR until the statement is paid in full.

11. Accounts greater than 90 days of age will be referred to an outside agency for recovery.

12. Failure to show for an appointment without prior notification may be billed as follows: $50 for the first occurrence, $100 for the second occurrence, and $100 for the third occurrence with possible discharge of care.

13. I authorize Lake Country Pediatrics, S.C. to send statements via email.

14. I agree to pay for any fees associated with collecting my account if it is referred to collections, including but not limited to: collection companies fee, interest, and legal fees.

By signing this document, you agree that you have read the information above and understand your financial responsibilities as a patient with Lake Country Pediatrics, S.C.

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Patient name (please print)

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Signature/Relationship to patient **Date**

Updated 1.1.2026