The Pediatric & Adolescent Center, Inc.
6148 N. Discovery Way Suite 100
Boise, ID 83713

William Bourquard, MD Nancy Miller, FNP-C

Patient Name: _____ DOB: _____

Financial Agreement

*****PLEASE READ COMPLETELY AND CAREFULLY*****

Co-pays, deductibles and/or previous balances are collected prior to each visit. We are happy to bill your insurance for you. However, payments not paid by insurance within 60 days will become the patient's responsibility. Your insurance contract is between you and the insurance company. The parents or guardians are financially responsible for unaccompanied minors.

We accept cash, check, MasterCard, Visa and Discover. There is a $20 service charge for all returned checks.

Insurance cards and driver's license/photo ID must be presented at each visit in order to accurately file insurance claims. Failure to present your insurance card will result in the denial of your insurance claims, therefore making the payment at the time of service required.

Any service denied by insurance, (I.E. deemed not medically necessary or non-covered service) will be billed to you, as you are the responsible party.

Our office will not be involved in domestic issues. The parent or guardian who signs for treatment of the patient is listed as the responsible party for the account and will be held responsible for the balance.

Payment arrangements are available for account balances. They may be extended for up to 4 months maximum and are due on a monthly basis. Absence of payments will void the arrangement and the full balance will be due and no other arrangements will be made. You are still responsible for co-pays and deductibles at the time of each service, even when you are making payment arrangements on a previous balance.

Any credits on any of your accounts for which you are the patient or guardian may be transferred between accounts to satisfy any unpaid balances. No refunds will be given on any over payments on your account(s). The credit balance can be used on future visits if necessary. *We reserve the right to discharge patients from the practice due to failure to make payments*

No Call/No Show Appointments

We ask that you please call our office at least 4 hours in advance if you will not be able to keep your appointment. We reserve the right to discharge patients from our practice that have neglected to notify the clinic three times that they were unable to keep their scheduled appointment. A fee of $20 will be charged for each no show. This fee is not billed to your insurance

I acknowledge that I am fully responsible for all costs incurred during my child/children's treatment at the Pediatric & Adolescent Center. I understand that any part of my account that is not paid within 60 days may result in interest to be charged to my account and that I am responsible for payment. I further agree to any and all legal collection costs on my account in full.

Patient Signature Date