FULL CIRCLE PEDIATRIC SOLUTIONS
P: 701-478-0221
F: 701-478-0222

4725 AMBER VALLEY PARKWAY, SUITE B,
FARGO, ND 58104
FULLCIRCLEPEDIATRIC.COM

Payment Policy & Fee Schedule

Thank you for choosing Full Circle Pediatric Solutions to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Full Circle Pediatric Solutions for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. We will provide you with an invoice outlining the services rendered and the amount charged.

Please read and check all boxes to acknowledge understanding and then sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Full Circle Pediatric Solutions will not become involved in disputes between me and my third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 30 days after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I understand that all cancellations must be made to the clinic or individual therapist by 8:00 AM on the day of my appointment and that there will be a $50 charge for any cancellation after this time that are not rescheduled before the next scheduled appointment. I also understand a $50 fee will be charged for "no show" appointments. I understand that this charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date