Great Kids Pediatrics

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FINANCIAL POLICY

Thank you for choosing our office to provide care for your child(ren). In order to prevent any misunderstandings and to serve you better, we ask that all parents read and sign our Financial Policy. If you have any questions, please ask a receptionist or a representative from our business office.

As a courtesy, we will verify your insurance eligibility and benefits at your initial visit and any time you notify us of a change in your coverage. However, we cannot guarantee that the information we receive is accurate (at the time of verification or for later visits) or that the insurance company will process the insurance claim in accordance with the information they provided. ***You, as the holder of the insurance policy, are ultimately responsible for knowing what your plan does and does not cover (like check ups and immunizations) and the administrative rules (like primary care physician selection, referrals, authorizations, etc.)***. You are also responsible for verifying that your doctor is participating in your insurance plan. Any amounts not covered by your plan, except for contractual fee discounts, are your financial responsibility. Please read and initial each item below:

1. **COPAYS AND/OR COINSURANCE AMOUNTS ARE DUE AT EVERY VISIT**. If I have a deductible to meet, I will pay your normal charges on the date of service. If a contracted fee discount applies, I understand that you will credit my account. These amounts can be applied toward future visits or refunded, whichever I prefer. I further understand that failure to pay my copay/coinsurance will result in an additional billing fee to be added to my account and ***every month*** until the balance is paid. _____

2. **BALANCES DUE PER THE EXPLANATION OF BENEFITS (EOB),** after my insurance plan has processed the insurance claim, are due immediately upon receipt of a bill from this office. If I disagree with the amounts due per the EOB, it is my responsibility to immediately contact my insurance plan for resolution of the problem. I understand that I may not withhold payment to your office pending resolution of insurance problems. If the insurance corrects the problem, I understand my account will be credited or I will be refunded any overpaid amounts. If my account has a credit from a separate date of service or sibling, I understand that credits will be used toward any outstanding balances. _____

3. **NEW INSURANCE INFORMATION** must be provided at the first visit after the change. I agree to provide this information before my child(ren) are seen. Failure to provide correct insurance information may result in the entire bill being my own responsibility._____

4. **INSURANCE REQUESTS FOR ADDITIONAL INFORMATION** to process claims must be responded to *immediately*. These include requests to verify if other insurance coverage exists, details of accidents/injuries, etc. Failure to provide this information in a timely manner may result in the entire bill being my own responsibility. _____

5. **BILLS ARE SENT THE FIRST WEEK OF EVERY MONTH** and as needed during the month. I will remit payment by check or credit card any balances due immediately upon receipt of a bill. I agree to contact the office immediately if I have questions regarding a bill I receive. *Bills are not sent for informational purposes only.* If I get a bill, it means the office expects payment from me. _____

6. **MISSED APPOINTMENTS:** I agree to cancel or reschedule appointments at least 24 hours in advance. Failure to do this, even for same-day appointments, will result in a No Show fee (currently $30) per occasion per child to be added to my account. Payment of the No Show fee is required prior to scheduling another appointment, and continued instances of not coming to scheduled appointments may result in the office requiring that I find another doctor or payment of the full cost of the office visit to be paid in lieu of the No Show fee. I understand that I can cancel an appointment by leaving a message in the voicemail system or with the answering service if the office is closed. _____

7. **BALANCES OVER 90 DAYS OLD:** I understand that if I allow my account balance to age more than 90 days, I may receive a Final Notice letter. Failure to pay my account or arrange a payment plan within 10 days may result in my account being turned over to a collection agency. If this happens, a Collection Fee (currently $35) will be added to my account balance. I will have to find another physician within 30 days. I understand that the collection agency will report unpaid balances to the major credit bureaus. Before my child(ren) can be seen in this office again, I understand that all fees, commissions, and taxes relating to collection agency involvement must be paid. _____

8. **CHANGES IN ADDRESS** or telephone numbers should be provided immediately. I will not wait until the next appointment, as bills or other correspondence will not reach me without a valid address on file. I understand that if the office cannot contact me via telephone or mail, my account will be turned over to a collection agency for further collection activity. (See Balances Over 90 Days Old for additional information on collection agency policies). _____

9. **RETURNED CHECKS** will incur a $30 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. If a second check is returned on my account, I understand that the office will no longer accept personal checks for payment. _____

10. **FEES SPECIFIED IN THIS POLICY** are subject to change without prior notice and will be applied to your account at the current rate. _____

Again, we thank you for choosing us to care for your family. We appreciate your trust and look forward to serving you. If you have any questions regarding our financial policies, please don't hesitate to ask. Please sign below to acknowledge understanding of the entire policy and that you were provided a copy for your records.

_____
Patient Name Date of Birth

_____
Parent/Guarantor Printed Name

_____
Parent/Guarantor Signature