

# Preferred Pediatrics Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

## **INSURANCE:**

Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide **ACCURATE** and **TIMELY** insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor/patient being responsible for payment. All patient balance questions should be made directly to your insurance for an explanation.

## **NON-EMERGENCY APPOINTMENTS:**

Well visits, physicals, any non-emergent follow ups and visits may be rescheduled if there are outstanding balances or co-pay is not paid at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy (including vaccine and doctor visit coverage, referral/authorization requirements for specialty care, x-rays, lab tests, emergency hospital care, ect.).

## **BILLING:**

We accept cash, checks, American Express, MC or Visa. Co-pays are due at the time of service. Deductibles and any patient responsible balances will be billed to the patient. Outstanding balances are due within 30 days of the statement date, unless prior arrangements have been made with the office. Balances not paid within the 30 days of the first statement date may be subjected to cancellation of your next appointment. Balances not paid in full within 90 days of the initial statement date will be forwarded to a collection agency. If your account should be forwarded to a collection agency, we will continue to see you/patient on an emergency basis only for 30 days after you have been sent to collections, giving you time to find a new source of medical care.

A \$25.00 fee will be charged for all returned checks and your account will be placed on a “cash or credit card basis only.” We will accept payments by cash or credit card only until the balance is cleared.

For any children seen, the accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital/custodial disputes. It is your responsibility to work out the payment of your child’s medical care between the custodial and non-custodial parent.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for payment arrangements and assistance in the management of your account.

Should your account balance become un-collectible due to bankruptcy, we will continue to see you/patient on an emergency basis only for the next 30 days giving you time to find a new source of medical care.

**IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY:**

All services performed in our office and at the hospital will be submitted as a courtesy to your insurance. All co-pays are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. All insurances carriers have a fee schedule from which they will reimburse. However, the doctor’s fee may be higher than that what the insurance company reimburses or may not be a covered service. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient.

**IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY:**

We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. \*\*\*Be prepared that you will not always be reimbursed the full price amount you paid for your services by our physicians. We will not reimburse you the difference between the reimbursement rate your insurance pays you and our fee for our services. Not all services provided by this office are a covered benefit in ALL CONTRACTS. Payment for services is **DUE AT THE TIME OF SERVICE**. If full payment is not made at time of service, your appointment is subject to cancellation.

**MISSED APPOINTMENT/LATE CANCELLATIONS:**

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for any missed appointments. Cancellations for physical exams are requested 24 hours prior to the appointment. A \$50.00 fee will be charged for any second, physical exam appointment missed. After a third missed physical exam appointment you will be charged another \$50.00 fee and our office may consider discharging you from the practice. This policy also applies for any other missed appointments: any sick visit/other scheduled visit requires a two hour cancellation time. If the visit is not cancelled within two hours, we reserve the right to charge you \$50.00 for that missed visit.

**ASSIGNMENT AND RELEASE:**

I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PREFERRED PEDIATRICS. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT/GUARANTOR.

Signature of Patient/ Responsible person: \_\_\_\_\_

Print name: \_\_\_\_\_

Date: \_\_\_\_\_