Partners In Health Pediatrics

Healthcare for Future Generation

Financial Policy

Please read completely& careful

Thank you for choosing us as your health care provider. We are committed to yours/your dependent's treatment being successful. Please understand that payment of your bill is considered a part of yours/your dependent's treatment plan.

The following is a statement of your financial policy which we require you to read and sign prior to any treatment. All patients /parents /guardians must complete necessary patient information forms prior to see the doctor.

INSURANCE COVERAGE

Your insurance policy is a contract between you and your insurance company, of which we are not a part of. We accept assignment from most insurance companies, however, in the event we do not; we will require you to pay for medical services rendered to you or your dependents. We will bill your insurance; however, the balance is your responsibility if the insurance does not cover any/all of the expenses. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance coverage. If your insurance does not pay for services, this balance will be transferred to you and will be your responsibility.

All co-pays/deductibles are due at the time services are rendered. If you are not prepared to pay the required amount, please let us know prior to seeing the provider. Be advised that any past due amount is your responsibility even if no bill/statement from our office is received by you.

If we are a participating provider of services for your insurance company and your policy requires you to pay a co-pay and/or deductible; as a network provider we are required to collect the co-pay and/or deductible from you as outlined in the policy as part of our contract with the insurance company. If your insurance coverage changes to a plan where we are not a participating provider the previous paragraph will apply to you. It is your responsibility to notify us immediately of any demographics and insurance changes. Any balances due to will be your responsibility.

USUAL & CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for your area. You are responsible for payment if your insurance company either denies or assigns all part of charges to be patient responsibility.

I agree to pay all charges and fees shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing with the clinic. Following charges/fees may apply:

$50 no-show fee for missing appointment or cancellation done less than 24 hours of appointment time. $15 late fee for each statement sent after 90 days past due. $35 fee for bounce/returned check fee. $25 fee for urgent referral request (less than 24-hour notice). $25 fee for school sports, medical records or any other documentation requested.

We prefer CASH, DEBIT & CHECK. Credit cards (Visa/Master) are accepted. Always ask for receipt, as it is the proof of your payment.

My signature below acknowledges that I have read, understand and *AGREE* to this financial policy as it applies to me and/or my dependents.

Patient/Parent/Guardian/Guarantor Signature: **Date:**

______________________________ ______________