FINANCIAL POLICY

We would like to thank you for choosing ABC Pediatrics as your child's medical home. We are committed to providing you with the best care possible. As your child's pediatricians, our relationship is with you and not your insurance company. Therefore, it is necessary for you to know what benefits your insurance plan has for you.

INSURANCE CARDS

It is your responsibility to provide us with your child's current insurance information at each visit.

If your insurance plan requires you to see a designated Primary Care Physician, please make sure we are listed as your child's Primary Care Physician prior to the appointment.

We will submit a claim to your insurance as a courtesy. However, any charges not covered by your insurance plan will be your responsibility.

PAYMENT OPTIONS

For your convenience, we accept cash, checks or credit cards (MasterCard, Visa, American Express and Discover).

Co-payments are due at the time of service. You are responsible for knowing your co-payment amount.

For patients with no insurance or a health care sharing program, full payment is required at time of service.

For patients with high deductible plans, payment is required within 30 days of the visit.

MISSED APPOINTMENTS / LATE CANCELLATIONS

If you are unable to make your appointment, please call us at least 24 hours in advance to cancel or reschedule the appointment. A "No Show" fee of $25.00 will be charged for missed appointments or late cancellations. If any members of a family no show/late cancel a total of three or more times combined in a 24 month period, the family may be discharged from the practice.

PATIENT STATEMENTS

Outstanding balances are due within 30 days. If you are unable to pay the balance in full, please contact the billing department to discuss payment arrangements.

A final notice for payment will be issued to patients with balances more than 90 days past due. Balances not paid in full after 90 days may be sent to a collection agency.

A $25.00 fee will be charged for any checks returned from a financial institution, plus any institutional fees incurred.

PATIENT FINANCIAL RESPONSIBILITY

I authorize payment of medical benefits by the insured directly to ABC Pediatrics PC, I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to my family member and for any yearly deductible or co-payment amounts. Furthermore, I understand it is my responsibility to know/understand my insurance plan benefits. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize ABC Pediatrics, PC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

I have read and fully understand this financial policy. I also understand that ABC Pediatrics, PC has the right to amend this policy at any time without prior notice to patients.

Patient Names (list all children): _____ Date: _____

Name of Parent or Guardian: _____ Signature: _____