Pediatric Associates

PAYMENT POLICY

Thank you for choosing Pediatric Associates as your child's primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have created this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. Please contact your insurance carrier to confirm that Pediatric Associates is an in-network provider. If we are not an in-network provider, payment in full is expected at time of service. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

2. Co-payments. Insurance carriers require all co-payments must be paid at the time of service. For high deductible plans without co-payments, a $30.00 payment will be required. If these payments are not paid at time of service, a $10.00 fee will be added to your account.

3. Non-covered services. Non-covered services are deemed by your contract with your insurance carrier. Please be aware that some of the services your child receives may be non-covered including but not limited to labs, developmental testing, hearing and vision screenings, etc. You will be responsible for all non-covered services.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card annually. If you fail to provide us with the correct insurance information in a timely manner, you are responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance carrier may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance carrier pays your claim. Your insurance benefit is a contract between you and your insurance carrier; we are not party to that contract.

6. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and all your children will be dismissed from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat your child on an urgent basis.

7. Missed appointments. Our policy is to charge $25.00 for missed appointments not canceled within 24 hours of the scheduled time.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ **_____**

Signature of patient or responsible party **Date**