Financial Policy

Our goal is to provide and maintain a good provider-patient relationship. Letting you know our office policies in advance allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments:

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- All children under the age of 18 must be accompanied by an adult. For well visits that require immunizations, a legal guardian must accompany any children under age of 18.

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Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you present your insurance card at every visit to verify that our office has the most updated card on file.
- If the insurance card/plan you present is incorrect, you will be responsible for payment of the visit unless updated insurance information is provided within a timely manner.
- If we are your primary care provider, make sure our name/phone number appears on your most up to date card. If your insurance has not been informed that we are your primary care provider, you may be financially responsible for your current visit.
- It is your responsibility to understand your benefit plan. Not all plans cover well child visits, vision/hearing screenings, or physicals. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

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Referrals:

- Advance notice is needed for all non-emergent referrals, typically 3-4 business days.
- It is your responsibility to know if a selected specialist participates with your insurance.
- Referrals can only be completed for conditions that have been documented by our providers. Urgent care/ER referral recommendations will require an office visit before the referral can be made from our office.

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Financial Responsibility:

- According to your insurance plan, you are responsible for any and all co-pays, deductibles, and coinsurances.
- Co-pays are due at the time of service. A $10.00 service fee will be charged in addition to your co-pay if not paid at the time of service.
- Self-pay patients are expected to pay for services in full at the time of visit.
- Patient balances are billed monthly and we ask that you pay your statement balance after receiving your first statement. A $15.00 fee may be assessed on all balance over 60 days old.
- If previous arrangements have not been made with our billing department, any account balances over 90 days old will be forwarded to a collection agency and all collections expenses will become your responsibility.
- For scheduled appointments, any outstanding balances must be paid prior to the visit or you will be asked to reschedule.
- We accept cash, check, and all major credit cards. Payments can be made online through the portal or through Instamed online. We also provide a credit card on file option.
- A $35.00 fee will be charged for any checks returned for insufficient funds and checks will no longer be permitted as a method of payment.
- Payment plans can be established for balances over $200.00 through our billing office. Convenient Monthly Payment Plans from Care Credit are also available for any charges less than 90 days old which allow you to pay over time with no annual fees or pre-payment penalties.

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Forms:

- There is a $25.00 form fee for completion of FMLA forms. The fee must be paid before forms will be completed. We require a 72 hour turnaround time.

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Prescription Refills:

- For monthly medication refills, we require 72 hours' notice, during regular business hours. Please plan accordingly.

Initial:______________

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Name:________________________________ **Date:**____________________________

Responsible Party's Name:______________________ **Relationship:**____________________

Responsible Party's Signature:____