ABC PEDIATRIC GROUP

Financial Policy and NO-SHOW Policy

We ask that you read this policy and aid us in keeping the costs down by ensuring that we can be reimbursed for our services on a timely basis. To help our office provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to our patients.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and keeping all changes up to date. It is your responsibility to notify our office of any change.
2. Make payment at the time of service for the entire balance if you are a self-pay patient, or for any deductibles, co-pays, or past-due balances that may be due.
3. Please do not discuss the financial aspects of your care with the provider(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the billing office staff on any account questions you may have.
4. If you have an HMO plan with a group insurance, you must select us as your Primary Care Physician prior to services being rendered, or the claim will be denied, and you will be billed for the visit.
5. All newborns must be added to your current insurance within 30 days. Otherwise, you will be responsible for the cost of the visit.

Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete insurance information. Patients must provide all information requested by the insurance company within 10 business days of the request, or the account may be collected as self-pay and a refund processed if insurance reimburses at a later date. Since we are not a party to the agreement between you and your insurance company, we ask that you contact them in the event that services are not paid within a reasonable time frame, i.e. 30 days. You are also authorizing ABC Pediatric Group and/or its employees to release any necessary information related to this visit and all future visits for the purposes of claim(s) payment. For "SELF PAY" patients, payment is due in full at the time of service. If we forward your account over to a collection agency, you will be responsible for the entire balance on your account plus any collection agency, attorney, or court fees. Returned checks are subject to a $25 returned check fee.

- I am authorizing the insurance company to pay any medical benefits for these services and all future claims to *ABC Pediatric Group* and/or the Providers.
- I am aware that insurance is a contract between the covered party and the insurance company. It is my responsibility to be informed of my benefits. Benefits vary between contracts as well as their reimbursements and patient coinsurances.
- I am aware that any balance due will require 100% payment, or a payment plan may be set up.
- I understand that if I fail to pay my account balance, it may be turned over to collections, and I will be responsible for collection fees up to but not to exceed 33% of the balance.

'NO-SHOW' / CANCELLATION POLICY

We ask that you provide a 24-hour notice for one child's visit and 48-hour notice for multiple children. The party responsible is required to pay a fee of $25.00 per no show. Nonpayment may result in dismissal. I have been advised of the No Show Policy and fee.

I acknowledge that I have read the above Financial Policy and NO-SHOW/Cancellation Policy, and I agree with it.

Patient Name: ____ Date of birth: _____________________

Print Responsible Party Name: _______________________________________Date: ___________

Signature____ Relationship to patient____________________