Patient Initial: _____ (DOB:) Patient Initial: _____ (DOB:)
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FINANCIAL POLICY

To reduce any confusion and misunderstanding between our patients and the office, we have adopted the following financial policies. If you have any questions, please do not hesitate to ask a member of our staff.

Health Insurance:

- For every appointment, our office staff will verify your eligibility prior to or upon check-in at each appointment. Please make sure you bring your insurance card to every appointment, and if your insurance changes, please notify us as soon as possible.
- We participate with many different plans and simply cannot know the benefits of every patient's policy. Therefore, we recommend that you make every effort to understand your insurance coverage. If necessary please contact your insurance company prior to receiving services in order to verify your coverage levels, copay, deductible, and coinsurance responsibilities.
- If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.

Non-covered Services:

- Please note that there are some services that your insurance may not cover.
- The services can be things such as, Vision tests, Hearing tests, Developmental screening tests, and In-office lab tests. Which are important tests that are considered as pediatric standards of care.
- If your insurance rejects the claim for services mentioned above, we will bill you at a discounted fee to ensure that you can afford the highest standards of pediatric care.

Newborns:

- **Please note that your insurance company will allow up to 30 days to enroll your newborn to your insurance policy. Our office will allow up to 30 days to hold the insurance claims for your newborn.**
- **If your insurance rejects the claim for missed enrollment or for any other reasons, you are financially responsible for the charges not covered by your insurance. We strongly advise you to enroll your newborn as soon as they are born and inform our office with the insurance policy information.**

Balances, Deductibles & Copayments:

- It is our responsibility, by the terms of the contracts with the health insurance companies, to collect copayments at the time of service, and to bill for personal responsibilities portion assigned by the insurance company.
- It is your responsibility to pay all outstanding balances. We are happy to set up a payment plan with you if you are unable to pay the balance in full at any time. Just make sure to set up a payment plan as soon as you receive the bill.
- If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file.

Secondary Insurance:

- In some circumstances you may have two insurers. In order to submit claims to both insurers, please provide us with insurance information as soon as possible.

Returned Checks:

- If your payment by check is returned from the bank for insufficient funds, you will be required to pay a fee of $50. If more than one check is returned in any given period, we reserve the right to require all future payment by credit card or cash to prevent this situation from recurring.

Credits / Refunds:

- Occasionally there may be a credit on your account. By signing below you authorize that any amount less than your copayment can be an offset against your next visit rather than refunded to you. Credits above your copayment amount will be refunded to you promptly.

Self-pay patients / Out-of-Network Insurance:

- If you do not have health insurance or if our office is are considered out-of- network for your insurer, the payment is due at the time of service.
- Upon request, our office can provide a claim form for you to submit to your out-of-network insurer.
- Please note that we will not return or collect the difference between what you have already paid vs. reimbursement from your insurance.

Guarantor:

- Whoever accompanies the child to each visit is expected to pay the charges due for the service rendered that day, including copayments, coinsurance, deductibles, etc. Divorce has no bearing on the responsibility for medical care as it affects third parties.
- The parent or guardian who signs the patient's paperwork is the individual who is responsible for all outstanding balances.
- Due to confidentiality, we can only bill the person who signs the patient's paperwork. Therefore, if the person responsible for the medical bill changes, the new guarantor must complete a new set of paperwork. In these situations, please inform us as soon as possible.

Divorce Decrees:

- This office is not a party to your divorce decree. All copayments and coinsurance are due at the time of service and are the responsibility of the accompanying adult. We will not bill another parent/guardian for the copayments or coinsurance due at time of service.

Form Fees:

- NO charge up to two forms at the time of the well child exam.
- Advance notice of 7 business days, especially for extensive medical records are needed.
- $5.00 per form for any other additional forms.
  *(Ex. school, camp, sports forms, Family and Medical Leave Act forms, asthma medication forms, pre-authorization/medication forms etc.).
- $5.00 (Will provide ***only*** CD records) Immunization record, Most Recent Well-Child Check Up, Growth Chart (**Cost will increase depending on extensive medical records**)
- $10.00 per form for any forms brought in at any other time than Well-Child Check Up.
- $20.00 for "Rush Service" forms that need to be completed within 48 hours.
- We require 7 business day turnaround time for forms brought in at any other time than Well-Child Check Up
- Payment is due when the forms are dropped off. There will be fee for any forms that needs to be mailed.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to My Kid's Pediatrics and Adolescent Care for any services furnished to my dependent or ward, and understand that failure to make payments timely may result in additional collection fees. I also understand and agree that the practice may amend such terms from time to time.

Parent/Guardian's Name (print): _____ Relationship to Patient(s): _____

Parent/Guardian's Signature: _____ Date: _____

The Financial Policies of My Kid's Pediatric and Adolescent Care, as well as our General Policies, are posted on mykidspediatricians.com.