OFFICE COPY

FINANCIAL POLICY DISCLOSURE FORM
April 4th, 2018

YOU WILL BE REQUIRED TO SIGN THIS FINANCIAL POLICY ONCE PER CALENDAR YEAR. **If you want a copy please ask at the time of signing.** You will be required at EVERY visit to show the patient's insurance card(s) and a photo ID.

This policy is complete and final and is subject to change at the discretion of the office.

Healthy Starts Pediatrics, P.C. has developed this financial policy so you have a clear understanding of your financial responsibility which is important to our professional relationship.

1. **INTRODUCTION:** We will make clinical recommendations, which we think are in your best interest, based on the American Academy of Pediatrics guidelines. We cannot, however, guarantee that your insurance will cover all or any of these charges. Knowing the coverage and limits of your health insurance policy is your responsibility. If both parents carry health insurance for the patient, the parent whose birth DAY AND MONTH comes first in the calendar year is usually the primary insurer.

2. **GENERAL:** The parent/legal guardian/authorized adult who brings the minor child to any visit is expected to pay co-pays and personal balances at the time of visit. This is regardless of legal or custodial arrangements. We do not get involved in financial disputes between parents. **By signing this document, you authorize Healthy Starts Pediatrics, P.C., to discuss personal balances with the authorized adult you have chosen to accompany the minor child(ren)to any visit.**

3. **INSURED PATIENTS:** As a service to you, we will accept "assignment of benefits" with participating insurance carriers. This service will NOT be provided unless our office is provided with all the necessary information regarding the patient's insurance. Insurance is a contract between you and your insurance company. If your insurance carrier denies your claim, or does not cover a service we have provided, it is your responsibility to make payment in full to our office. Your insurance company may need you to supply them with certain information in order to process claims, called Coordination of Benefits. It is your responsibility to comply with their request or you will be billed for the service. Failure to pay this balance or to provide COB will result in dismissal from the practice and a bill for the balance. If your Auto insurance/Health insurance has not provided payment in full to our office, you will become responsible for any outstanding balance due.

4. **MANAGED CARE (HMO) PATIENTS**: Please provide the proper insurance plan identification. All co-payments are due at the time of service. It is your responsibility to confirm that we, Healthy Starts P.C., are the chosen Primary Care Physician (PCP) for your child/children on the date of service. You will be responsible for charges not covered if we are not the chosen PCP.

5. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor, must show proof of insurance and show a valid driver's license. If you fail to provide us with insurance information in a timely manner, you may be responsible for the balance of the claim. Note that **if you withhold information about an active insurance policy from us that delays the filing or payment of a claim, or fail to notify our office about a medicaid plan, you may be dismissed from the practice due to non-compliance with legal insurance practices.**

6. **FEES: You will be charged $10.00 if your co-pay is not paid on the date of service. There is a fee of $25.00 for all returned checks. A $10.00 fee is charged for forms that are completed if they are needed at any time other than during an appointment with a provider.**

Broken appointments are not a covered service by insurance plans and as such are a cost to us, you and other patients who could have used that appointment. **By signing this policy, you acknowledge that you are expected to give a minimum of 24 hours notice for Wellness exams and other non-urgent appointments, and a reasonable notice for urgent or same-day appointments, preferably 2 hours when possible.** All patients will receive a reminder call and / or letter upon the 1st missed appointment. Patients will be charged a $50.00 No-Show fee per child for the 2nd missed appointment in a 2 year period if not cancelled within the above time frames. If the appointment was a well check for 2 children, we will not schedule future 'double' checkups. For patients with ANY insurance, upon the 3rd missed appointment in a two (2) year period that is not cancelled within the above time frames, a letter of dismissal will be sent to the family along with a record release so that record may be expedited to the new Pediatrician or Provider.

A $5.00 monthly billing fee will be charged on all bills for any previously unpaid balances. Our office accepts Cash, Visa, MC, American Express, Discover, Checks. Post-dated checks will not be accepted. When you provide a check as payment, you authorize us to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. If a check is returned for non-sufficient funds, another form of payment may be required for future payments.

7. **SELF-PAY PATIENTS**: Patients without insurance who choose to utilize our services on a self-pay basis are expected to pay the entire balance in full on the day of service and therefore, will be given a 20% discount at this time. For those with insurance who request to bypass insurance, you must have an insurance that allows this (Medicaid and some HMOs do not), and you must pay IN FULL at the time of the visit in order to qualify for this service.

8. **PERSONAL BALANCE**: If you have a personal balance and are not able to pay it in full, you must contact our billing office to set up an approved budget payment plan. A $25.00 minimum budget payment is required on all personal balances every 30 days to remain in good standing with our practice. If payment in full is not received after 90 days, your account may be sent to a collection agency and you may be dismissed from our practice.

ASSIGNMENT OF INSURANCE BENEFITS

I assign all medical and surgical benefits to which I am entitled, to Healthy Starts P.C. I understand that I am financially responsible for all charges not paid by my insurance carrier. I authorize Healthy Starts P.C. to release all information necessary to secure payment.

By signing my name, I am stating that I have read, understand and agree to the terms and conditions set out above.

**YOU WILL BE ASKED TO SIGN OUR ELECTRONIC SIGNATURE PAD **