Guilford Pediatrics

152 Broad St. Guilford, CT 06437 203-453-5235 Fax 203-453-6204
Nancy Czarkowski, MD Dia Flanagan, MD Ann Hoefer, MD Robert Nolfo, MD Jonathan Stein, MD
Kathryn Kruser, APRN

FINANCIAL POLICIES

Initial _____ **INSURANCE PLANS**: I understand that my enrollment in my insurance plan is a contract I have with the carrier and not with the practice. Decisions about coverage are determined by the carrier. I understand that it is my responsibility to know my insurance benefits, including in-network vs. out-of-network coverage, and to know that Guilford Pediatrics is participating with my plan. **Any questions about medical, well/preventive care, labs/x-rays and immunization coverage should be directed to my insurance carrier prior to my visits.** In particular, not all insurance plans cover specific lab tests, hearing, vision or development screens, or may only allow partial coverage. I understand that coverage for services varies greatly amongst insurance plans, and it is my responsibility to know my insurance benefits.

Initial _____ **INSURANCE CARD:** I understand that presenting my insurance card at each visit, if requested, is my responsibility. If I have changed insurance carries, **or carry secondary insurance**, it is my responsibility to alert the front desk of either of these circumstances. I agree to pay any uncovered charges that result from not presenting accurate information at the time of the visit. I understand that any false misrepresentation of insurance coverage can lead to dismissal from the practice.

Initial _____ **COPAYS, DEDUCTIBLES, SELF PAY:** I understand that it is my responsibility to know my current copay. I agree to be respobible for all copays, deductibles and non-covered services determined by my insurance plan. If i do not have insurance coverage at the time of services rendered, I understand that FULL payment is due at the time of service.

Initial _____ **COMBINED VISITS:** I understand that at well child exams, if other health concerns are brought up that would typically require a sick visit, my insurance company may consider these two seperate visits and require a copay and bill other charges accordingly.

Initial _____ **PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. If I need help in setting up a payment plan, I will contact the billing dept, knowing that payment plans must be strictly adhered to. If I do not pay my bill, or have not kept current with my payment plan, it can lead to dismissal from practice.

Initial _____ **FINANCE CHARGE:** I understand that if my account is more than 180 days past due a $5 per month finance charge will be assessed per past due balance. If you have a payment plan set up and are making monthly payments no finance charge will be assessed on your account.

Initial _____ **RETURNED CHECKS:** If a check is returned to us from your bank, you will be charged a $15 check fee.

Initial _____ **CHECK IN:** I agree to pay copays and pastdue balances at the time of check in.

Initial _____ **REFERRALS AND PRE-AUTHORIZATION:** I understand it is my responsibility to know if a written referral or pre-authorization is required for any specialist or procedures to which I am referred and to know what services are covered.

I have read, understood and agreed to the above financial policies.

Patient Name_____ Date of Birth_____
(Please Print)

Patient, Parent or Guardian Name_____ Date of Birth_____
(Please Print)

Patient, Parent or Guardian's Signature_____ Date_____