



Financial & Administrative Fee Policy

Sound Beach Pediatrics participates with most insurance plans. Each insurance policy is different, and it is therefore impossible for us to know what are your particular benefits may be. Therefore, it is very important that you contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made by check or by credit card. We also accept Health Savings Account (HSA) cards for payment. We do not accept cash payments.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time that those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Credit Card on Fileⁱ

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email.

2001 WEST MAIN STREET | SUITE 132 | STAMFORD | CT 06902

TEL: (203) 363-0123 | FAX (475) 619-9855

www.SoundBeachPediatrics.com

(v.2018)



If you would like to make arrangements to pay the amount by installments, please notify the office in advance

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance.

Administrative Feeⁱ

At Sound Beach Pediatrics, coordination of care is central in making sure that our patients receive high quality healthcare. This means several hours are spent providing services that insurance does not cover, including providing a patient portal and filling out any forms needed for school, camp, sports, or daycare.

To cover that administration, we charge a small annual fee of \$50 per child up to a maximum of \$200 per family. You may choose to opt out of the annual administrative fee and pay a-la-carte for these requests instead. A \$25 fee will need to be charged for each request, including any school entry, annual school physical, sports and camp physical forms. Please fill out your choice below to indicate your preference.

No-Show and Late Policy and Fees

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require **at least 24 hours notice** for all cancellations. Failure to notify our office in a timely manner will result in a **no show fee for a sick visit of \$50**, and a **no show fee for a well visit of \$100**.

Patients who arrive 10 or more minutes late for a sick or well visit may not be able to be seen. Late arrivals that cannot be accommodated are considered missed appointments. A no show fee will be applied (\$50 for missed sick visit and \$100 for missed well visit).



Repeated no-shows or late arrivals are unfair to our providers and strain our practice. **Sound Beach Pediatrics will ask that families with repeated late arrivals and/or no-shows to transfer care out of our practice.**

Additional Fees

We charge a returned check fee of \$30.

I have read and understood the above policy and agree to it.

I select (please circle your choice) the following choice for our family's Annual Form Fee:

- Option 1 = \$50 per patient for 2017 (paid at the time of the first visit in 2017)
 - Family maximum \$200.00 per year
- Option 2 = \$25 per form (paid at the time the form is requested)

Signature _____ Date ____/____/____

Printed Name _____

Relationship to patient(s) _____

<u>Patient Name</u>	<u>Date of Birth</u>	<u>Amount</u>
1.		
2.		
3.		
4.		
5.		
6.		

TOTAL: _____

(Option 1 capped at family maximum \$200)

ⁱ No administrative fees will be charged to patients with Medicaid and Medicaid HMO insurance

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