**FINANCIAL POLICY**

Pediatric Partners, LLC is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy. For more details visit our web site: www.pediatricpartnersmd.net.

**Insurances:** We participate with several insurance companies. Please check with the office to see if we participate with your plan. All patients will be responsible for presenting their insurance card at every visit and for completing a new patient registration yearly.

**If we DO participate with your Primary or Secondary insurance company,** all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. All copays, co-insurances, deductibles, including non-covered after-hours charges, are the patients' responsibility. All patients are responsible for ALL copayments at the time of service. Deductibles, co-insurances, and non-covered services will be billed to you by our billing office. It is our primary goal to provide the best healthcare for your children. In order to do this, we provide a variety of services in our office. These services include labs, tests, procedures and "After Hours Care"; which are after 6:00 PM, Saturdays & Sundays during regular business hours. This is considered a convenience service. Some of these services have additional charges associated with them. Most are recognized by insurance companies. Patients may be required to pay additional amounts for these services depending on the type of insurance plan you have and your coverage.

**If we DO NOT participate with your insurance company,** this means that we do not bill your insurance carrier: and, we will not accept payment from them as payment in full for the services performed. We do not participate with PIP plans. Any balance not covered by the insurance company becomes the responsibility of the patient. Payment for services rendered in the office **IS** due at the time of service. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

**If you do not have insurance, or, an insurance card is not presented,** all services performed will become the responsibility of the patient. Payment for services rendered in the office **IS** due at the time of service.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account.

**Records, Forms and After-Hour Calls:** If you would like a copy of your record sent to another doctor or organization, you will need to request in writing, and pay a $20.00 fee per medical record, or the fee that is charged by an outside company, (no family discounts). You will also be asked to pay a reasonable fee of $15.00 for completion of each summary and immunization form. In addition, you will be charged a fee of $15.00 for all after-hour calls.

**Missed Appointment Charge:** Effective November 1, 2008, we will begin charging $25.00 for all missed appointments.

**Telehealth:** Depending on your concern, your provider may feel that a telehealth appointment is indicated. By signing, you give consent for a virtual visit. You acknowledge the limitations of a virtual visit through a synchronous telecommunication system and that a provider may decide that a face to face visit may be indicated after the telehealth visit. You also acknowledge that this virtual visit will be submitted to your insurance company for payment but that ultimately you are responsible for any copayments, deductibles, or uncovered portions that your insurance company deems is the patient's responsibility.

**It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor.**

**Payment for services performed:**
Our office accepts AM/EX, VISA, Discover and Mastercard for your convenience, as well as cash or a check. Each bounced check will be assessed a fee of $36.00. This fee is the responsibility of the patient and not the insurance company. **All copayments not paid at the time of service will be assessed a service charge of $10.00 per copay. All payments are expected at the time of service and any outstanding balances are due within 30 days of billing unless prior arrangements have been made with the Billing Department.** All balances that reach 90 days may be sent to a collection agency. Balances sent to the collection agency will be reported to a credit reporting agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future unless prior arrangements have been made with the billing office.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PEDIATRIC PARTNERS LLC, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

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Signature of Patient and/or Guardian (SEAL) Date

Patient Name(s) _____

Updated:12/10, 5/11, 12/11,12/13,12/14,12/15,3/17,1/18,6/19,10/19,1/20,6/20