Financial Policy

Thank you for choosing us as your child's health care provider. We strive to provide the very best care for you and your family. It is important for our patients to understand their financial responsibilities.

Please make sure you bring your current insurance card to every appointment. We will ask you at each appointment about your current telephone number and address so that we have the correct contact information. For newborn babies, please make sure that you add them to your primary insurance plan in the first 30 days of their life. A newborn baby's initial visit to our office is typically considered a hospital follow up visit. If you have a secondary insurance, please inform us and your insurance company. If you have Caresource or Medicaid, you need to inform them periodically as to whether or not you have any other insurance. We need to have the most up to date information in order to file the medical claim with your insurance company.

Copays

If your insurance requires a copay, please make sure you pay it at the time of service. If the copay is paid more than 24 hours after your appointment time, you will be charged an additional $10. Most insurance companies do not require a copay for a well visit (yearly exam, complete physical exam, sports physical). **However, if an acute or chronic medical problem is addressed during this visit, there will be an additional charge that may require a copay and it may be applied to your deductible.**

Appointment Cancellations

If you need to cancel or reschedule a yearly physical or any appointment made more than 1 day in advance, please do so at least 24 hours before your appointment time. If you cancel or reschedule your appointment later than this or if you do not show up for your appointment, it will be counted as a missed appointment and you will be charged a $25 fee. For appointments made on the same day, please cancel or reschedule at least 2 hours prior to the appointment time or it will be counted as a missed appointment and you will be charged a $25 fee. Any patient or family who miss too many appointments will be discharged from the practice.

Billing and Collections

Our billing staff will submit the bill for your appointment with your insurance company. For any patient balance due for more than 60 days, $5 per month will be charged to your account until the balance is paid off. This is to cover the cost of sending additional bills and statements. If a check is returned because of insufficient funds, you will be charged a $25 fee to cover the bank costs. If there are two returned checks, you will have to pay by cash or credit card.

If you do not currently have insurance coverage, we can offer a 30% discount on the appointment charge if it is paid at the time of appointment. Please inform us when you arrive for that appointment that you do not currently have insurance.

If you are unable to pay your balance in full, please contact our billing department. We may be able to set up a payment plan to help you. Unfortunately, if an account balance is unpaid over a prolonged period of time you will be sent to a collection agency and we will no longer be able to provide care to your child and family. If you are sent to collections, a charge of 35% of the balance will be added to your account to cover the costs of the collection agency. If you declare bankruptcy and list our practice as a creditor we will no longer be able to provide care to your child or family.

Weekend/Evening Appointments

There is an additional charge of $25 for all Saturday appointments, as well as appointments 5pm or later Monday through Friday. This may or may not be covered by your insurance. Sometimes, your insurance company will require you to pay this fee.

Transfer of Records

To obtain a copy of your or your child's medical records, we will need a signed medical records release form. There is a charge of $10 per child per occurrence.

_____ _____

Signature of Parent/Guardian Date

_____ _____ _____

Printed Name of Parent/Guardian Patient Name DOB

_____ _____

Patient Name DOB

_____ _____

Patient Name DOB

_____ _____

Patient Name DOB