PEDIATRICS OF NORTHEASTERN PENNSYLVANIA

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at time of service. A **$10 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 30 days of your receipt of your bill.
10. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 30 days will be charged a $5 re-bill fee. Any balance over 90 days will be forwarded to a collection agency.
11. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card to remain on file.
12. Not showing up for an appointment will result in a charge of $35 on the patient's account. This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances. No show appointments can result in the patient being discharged from the practice at the discretion of the practice. Fees are subject to change.
13. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
14. We charge to copy or transfer medical records.
15. If your child has school, camp, or sport forms to be completed, there is a **$5** charge per form. Payment is due when the forms are dropped off. We have a 3 to 5-day turnaround time for forms. If a form is needed before then, there is a **$10** rush fee.
16. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
17. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
18. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)

_____ _____ _____

Responsible party name and signature Relationship Date