

Practice Name
[Year] FINANCIAL POLICY

The following is a summary of **(Practice Name's)** Financial Policy.

ACCOUNT RESPONSIBILITY

The guarantor (the person responsible for payment on the account) is defined as the individual whom the child/children live with more than 50% of the time and/or is the individual who gives consent for treatment. If you are in a situation where there is a court order identifying another individual responsible for any portion of medical care provided, payment is expected from the guarantor. We will be happy to give you a receipt or itemized statement that can be forwarded to the appropriate individual. Failure to pay monies owed to **(Practice Name)** is a serious issue that could potentially lead to your family's dismissal from all **(practice name)**. _____ **(INITIAL)**

INSURANCE PLANS ACCEPTED

*We accept most insurance plans. Most insurance plans have policies that require co-payment at the time of service. **YOU** are responsible for payment of all co-pays and any outstanding balances at the time of visit. A \$5.00 billing fee will be applied to your account if your co-pay is not paid at the time of the visit. If you are covered under an HMO or other managed care plan (Point of Service or PPO), there may be specific coverage limitation. You are responsible for services that are not covered by your insurance plan. A \$25.00 fee will be added to your account for any check returned from the bank as unpaid.* _____ **(INITIAL)**

BILLING YOUR INSURANCE

(Practice Name) will make every effort to accurately bill the insurance company with the information you have supplied. Occasionally delays occur in claims processing and we may need to contact you for additional information. However, **(Practice Name)** is not a participating provider for all insurance companies. It is your responsibility to contact your insurance carrier to verify if the Practice Group you are seeing is a participating provider for your insurance. We do not participate and/or bill Major Medical plans.

PAYMENT DISCOUNT AT TIME OF SERVICE

If you do not have insurance or if your insurance plan does not cover certain services, you will be expected to pay for services in full at the conclusion of your visit. To acknowledge the savings in billing and collection costs from not needing to bill an insurance company, we are pleased to offer a same-day as services rendered payment discount to you. **We accept cash, personal check, ATM card, MasterCard and Visa.** In addition to this payment discount, we may offer payment arrangements. Families experiencing financial difficulties can contact our business office at **(phone number)**.

BALANCES AFTER YOUR INSURANCE

YOU are responsible for any remaining balance (due to co-insurance, deductible or non-eligibility) that exists after your insurance has paid. If we know what the balance will be at the time of your appointment, you are expected to pay upon check-out that day. **We accept cash, personal checks, MasterCard and Visa.** Otherwise, we will send you a statement in the mail. Payment is due upon receipt. After 90 days, all accounts with balances are turned over to a collection agency. **A \$25.00 billing fee will be assessed to any account over 90 days.** _____ **(INITIAL)**

BENEFITS INTERPRETATION

We are happy to assist you in interpreting requests from your health insurance carrier to ensure that your claims are handled appropriately and your balance is accurate. However, **it is your responsibility to understand which services are covered and which are not covered under your plan.** Likewise, it is your responsibility to identify any coverage changes that may be initiated by your employer or managed care insurance plan. If you have any specific questions, we encourage you to contact your insurance company prior to your appointment.

QUESTIONS REGARDING YOUR BILL

If you have any questions on the bill you receive, please contact our billing office at **(phone number)** weekdays between 8:00AM and 4:30PM. Should you receive specific statements from your insurance company that are unclear, **you are encouraged to contact your insurer for clarification before contacting our business office.**

I have read and understand the above financial policy.

Parent/Guarantor Signature _____ Date _____