



Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, and will bill participating insurance companies as a courtesy to you. If we do not receive a payment from your insurance company within 45 days of the date of service, you will be expected to resolve the balance. You are responsible for all charges. We also bill secondary insurances as a courtesy to you. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we do business, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Managed Care. If you are enrolled in a managed care insurance plan (i.e. HMO) you must receive a referral from our office before seeing a specialist. Retroactive referrals will likely be denied by your HMO.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service unless other arrangements have been made. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. First Steps Pediatrics accepts cash, personal check, visa and master card. There is a service charge for returned checks of \$30.00.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered insurers. You may be responsible for payment of these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current photo identification and current, valid insurance to provide proof of insurance. If you are not able to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. Patients with a balance outstanding more than 60 days must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty and we are available to discuss, in confidence, options, which may be suitable to your situation. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed Appointments/Late Cancellations: Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date