Kids & Teens Primary Healthcare, P.C.

Financial Policy

Patient Name ____ **Date of Birth** ____________________

We ask that you read this policy and aid us in keeping the costs down by ensuring that we are able to be reimbursed for our services on a timely basis. To help our office provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to our patients. We are available to discuss our financial policy upon request.
To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date. It is your responsibility to notify our office of any change.
2. Make payment at the time of service for the entire balance if you are a self pay patient, or for the amount of any deductibles, co-pays, or past due balances that may be due.
3. Discuss your account balance only with the check-out or business staff. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the front office staff on any account questions or problems you may have.

Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete insurance information. Patients must provide all information requested by the insurance company within 10 business days of the request or the account may be collected as self pay and a refund processed if insurance reimburses at a later date. If you have insurance and we file with your carrier, we ask that you pay ahead of time on the balance which is your responsibility according to your plan, i.e. any deductibles, co-pay, or co-insurance amounts. For some plans, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within a reasonable time frame, i.e. 60 days. You are also authorizing *Kids & Teens Primary Healthcare* and/or its employees to release any necessary information related to this visit and all future visits for the purposes of claim(s) payment. If you do not have insurance and are not covered by Medicaid or Peachcare plans, you will be considered a "SELF PAY" patient. Payment is due in full at the time of service. If there is an incorrect Primary Care Provider attached to the insurance, then the appointment may be rescheduled if not corrected by the date of service. This assists us in cutting down on billing and operating expenses. Failure to give notice 24 hours prior to missing your appointment may result in a $25 fee for office appointments. Interest may accrue on any unpaid account without a satisfactory payment plan. If we need to forward your account over to a collection agency for further legal action, you will responsible for the entire balance on your account plus any collection agency, attorney, or court fees. Returned checks are subject to a $25 returned check fee.

- I am authorizing the insurance company to pay any medical benefits for these services and all future claims to *Kids & Teens Primary Healthcare*, Dr. Byron Cotton.
- I am aware that the insurance is a contract between the covered party and the insurance company. It is my responsibility to be informed of my benefits. Benefits vary between contracts as well as their reimbursements and patient coinsurances.
- I am aware that any balance due will require 100% payment or a payment plan may generally be set up for a period of 90 days.

Parent / Guardian (Please Print) ____

Signature Parent/ Guardian ____________________________________ **Date** __________