

KIDS FIRST PEDIATRIC PARTNERS

FINANCIAL POLICY

Responsibility:

When a patient is registered with Kids First Pediatric Partners, we ask that the parent or guardian seeking care accept final responsibility for payment. Your insurance coverage is an agreement between the employer/employee and the insurance company. Policies that require a Primary Care Physician (HMO's, AllKids) please remember to select a Kids First Pediatric Partners provider. Parents and guardians will be held responsible for understanding coverage limitations and will be responsible for dollar amounts not covered by their insurance.

Co-Pays:

Co-Pays are due at time of service, each time your child visits our office. There will be a \$10 fee assessed each time a co-pay is not rendered at time of service. If you are unsure of your co-pay amount please contact your insurance company for confirmation of co-pay amounts prior to coming to the office.

Other reasons payments are due at time of service:

1. Self pay accounts
2. Insurance coverage by a policy we do not participate in
3. Inability to verify insurance eligibility
4. 1 month old with no coverage identified and verified

Secondary insurances:

Kids First Pediatric Partners does not accept ALL Kids as secondary coverage. All other secondaries will be billed once. Any remaining balances will be parent/ guardian responsibility.

Professional Services Rendered:

If your child is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed.

Refunds:

Refunds will be issued on accounts with a credit of \$50 or more. All accounts with credits less than \$50 will have funds held for use at future visits.

Cancelled/ Missed appointments:

Appointments must be cancelled 24 hours prior to your scheduled visit. If a sick visit appointment is missed (no-show), there will be a \$25 fee applied to your account. Payment of these assessed fees will be required prior to your next visit. Repeated missed appointments may result in discharge from the practice.

Balances:

All outstanding balances resulting from Co-insurance, deductibles, non-covered services, benefits maxed, etc., are due within 14 days upon receipt of your financial statement from Kids First Pediatric partners. Failure to pay these balances may result in further collection activity or dismissal from the practice.

Payment plans:

We, at Kids First, understand families may be undergoing a financial hardship, therefore we do offer payment plans. Your first payment will be due upon signing of the written agreement. Payment amounts will be based on amount owed. No payment plan will be given to amounts less than \$100.

If your payment plan is in default the balance will be due in full. Failure to pay may result in further collection activity or dismissal from the practice.

Miscellaneous fees:

NSF-returned checks: \$25 fee and all future payments must be cash or Credit /Debit card.

Medical records given to parent/guardian: .10 per page plus \$10 processing fee.

\$15 fee for administration of alternative vaccine schedule.

\$45 fee for Ear piercing

\$15 fee for fluoride. (Commercial insurance and self-pay only)

\$10 each replacement form. 1 free form given at time of visit.

A 30% collection fee will be added to each account placed with an outside collection agency.

I agree to pay for any and all medical services I receive from this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf; however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive medicine visits), I will pay for same upon written/verbal notice of their refusal.

I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

I authorize the release of any medical information necessary to process any claims, either to myself or any parties who request this information.

Signature of Parent/Legal Guardian Name (please print)

Date