FINANCIAL POLICY

KIDS FIRST
PEDIATRIC PARTNERS

Kids First Pediatric Partners
Concourse Office Plaza, Tower 2
4709 Golf Rd., Ste. 900
Skokie, IL 60076
Phone: 847.676.5394 Fax 847.679.7183
www.kidsfirstpediatricpartners.com

Responsibility
When a patient is registered with Kids First Pediatric Partners, we ask that the parent or guardian seeking care accept financial responsibility for payment. Parents and guardians will be held responsible for understanding coverage limitations and for dollar amounts not covered by insurance.

Patient Payments Due at Time of Service
1. Copays and deductible (*There will be a $10 late fee assessed each time a copay or deductible is not paid at the time of service.*)
2. Services and purchases made at time of service

Secondary Insurance
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.

Canceled/Missed Appointments
Regular appointments must be cancelled 24 hours prior to your scheduled visit. There will be a $35 fee added to your account for all No shows. Easy Breather and Nutritional appointments require 48 hour notice. There will be a $50.00 fee added to your account for these No shows. 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 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
Because we understand families may undergo financial hardship, 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: $35 fee and all future payments must be cash or credit /debit card.
Medical records given to parent/guardian: $.25 per page.
$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.
$30 fee for after normal business hours added to any visit on the weekends and holidays and after 5PM Monday through Friday.

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 that may include but are not limited to vaccines, developmental screenings, vision and hearing screenings, strep test, flu test and urine dips or insurance 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. I acknowledge that I have received a copy of the Financial Policy for my own records. Policy subject to change. Updates will be posted on our website.

Signature of Parent/Legal Guardian _____ Date _____

Printed Name _____ PCC Account Number _____

Additional copies of the Financial Policy are available on our website www.kidsfirstpediatricpartners.com under patient forms.