

Southwest Pediatrics Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at EVERY VISIT. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your child's behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialist, if preauthorization is required prior to a procedure, and what services are covered. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. Remember your primary care physician must approve referrals before being issued.
4. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
5. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balance must be paid prior to the visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service. A \$15 processing fee (or service fee) will be charged in addition to your co-payment if the co-payment is not paid at time of service.
8. If you do not have a scheduled appointment there will be an additional \$ 20 walk-in fee to any service provided.
9. We require 24-hour notice for canceling any appointments. There is a \$20 charge for sick office appointments and \$ 40 charge for Well child appointments if they are not canceled or if 24-hour notice is not given. We do not accept cancellations through our answering service.
10. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your Remittance is due within 10 business days of your receipt of your bill.
11. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a \$10 re-bill. Any balance over 90 days will be forwarded to a collections agency. We reserve the right to charge interest in the amount of 18% for patient balances over 60 days.
12. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remains on file. There are addenda to this financial policy, which are signed separately.
13. A \$ 35 fee will be charged for any checks returned, plus any bank fees incurred.
14. We have a medical records fee of \$25.00.
15. If your child has a school, camp, sports forms etc. to be completed, there is a \$10 per page. Payment is due when the forms are dropped off. We have a 3 to 5 day turnaround time for forms. If a form is needed sooner than 3 days, there is an additional \$5 rush fee.
16. For all vaccines voluntarily separated from the physical/well child appointment (by parent) there will be a \$ 25 charge for any additional appointments.
17. All requested immunization records will be charge a \$5 processing (service) fee.
18. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. **It is your responsibility to know your insurance plan benefits.** If it is not covered, you will be responsible for payment at the time of service.
19. Not all Services provided by our office are covered by every plan. **Any service determined to not be covered by your plan will be your responsibility.**

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

Responsible party (guarantor) name

Relationship

Responsible party (guarantor) signature

Date